

6768

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>md.</i>		COUNTY <i>Montgomery</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <i>Takoma Park</i>		<i>14 da.</i>		TOWN <i>Takoma Park md</i>		<i>17</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<i>17 Penic one -</i>				<i>17 Penic one -</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<i>Barry Lee Ackerman</i>				<i>July 29 1955</i>			
5. SEX:	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>m.</i>	<i>wh.</i>		<i>Mar 15, 1955</i>	<i>4</i> yrs.	<i>4</i> Months	<i>11</i> Days	<i>0</i> Hours <i>0</i> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
				<i>Takoma Park, md.</i>		<i>USA</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Orva L Ackerman</i>				<i>Edith Griffiths</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
				<i>Orva L Ackerman - 17 Penic one T.P.</i>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE							
(A) DUE TO							
ANTECEDENT CAUSE (B):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO <i>Hydrocephalus.</i>							
(C) <i>Birth abnormality.</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Mar 15, 1955</i> , to <i>July 28, 1955</i> , that I last saw the deceased alive on <i>July 28 1955</i> , and that death occurred at <i>1:09 AM</i> , from the causes and on the date stated above.							
SIGNATURE <i>Keith Stantard</i>				ADDRESS <i>M. D. Wash San + Hosp.</i>			
				DATE SIGNED <i>July 29, 1955</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Transit. Burial</i>		<i>July 29, 1955</i>		<i>Lambertville</i>		<i>Pa</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>July 19 1955</i>		<i>J. William Dodel</i>		<i>G. Arthur Eckert</i>		<i>254 Canal St NW</i>	
				<i>Takoma Park D.C.</i>			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ju 5-5461

RECEIVED
AUG 2 1955
BUREAU V. S.

6796

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>District of Columbia</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington, D.C.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda Rural</u>		LENGTH OF STAY (In this place) <u>45 Min</u>		STREET ADDRESS (If rural give location) <u>13 Jib Green, S.W.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington, D.C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>13 Jib Green, S.W.</u>			
3. NAME OF DECEASED: (Type or Print) <u>Margaret</u>		(First) (Middle) (Last) <u>(N) ACOSTAR</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July 29 1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Malayan</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>29 July 1955</u>	9. AGE last birthday <u>45</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>	11. BIRTHPLACE (State or foreign country): <u>Bethesda, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Atanacio ACOSTAR</u>				14. MOTHER'S MAIDEN NAME: <u>Confesor MIRANDA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Father Atanacio ACOSTAR Same as above</u>		
15. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH <u>45 min</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>770.5 Prematurity</u>							
ANTECEDENT CAUSE (S) <u>(Hydrops fetalis)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Hemolytic disease of undetermined type</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Microcephaly</u>							
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>29 July, 1955</u> to <u>29 July, 1955</u> that I last saw the deceased alive on <u>29 July, 1955</u> , and that death occurred at <u>5:00AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Howard A. Pearson</u>				ADDRESS		DATE SIGNED	
H. A. PEARSON LTJG. MC, USN, U.S. Naval Hospital NNMC, Bethesda, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>7-30-55</u>		NAME OF CEMETERY OR CREMATORY <u>MT OLIVET</u>		LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-29-55</u>		REGISTRAR'S SIGNATURE <u>Mary E. Carrelly</u>		24. FUNERAL DIRECTOR <u>R. A. Humphrey Funeral Home</u>		ADDRESS <u>7557 Wisconsin Avenue, Bethesda, Maryland</u>	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

20753/3283

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 1 1955

BUREAU V. S.

6797

CERTIFICATE OF DEATH

Reg. Dist. No. 512

1. PLACE OF DEATH: <u>Kensington Nursing Home</u>		USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>MONTGOMERY</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Kensington</u>	LENGTH OF STAY (in this place) <u>7/7/55 - 7/22/55</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cherry Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kensington Gardens Nursing Home</u>	STREET ADDRESS (If rural give location) <u>4417 Bradley Lane</u>		
3. NAME OF DECEASED: (First) <u>John</u> (Middle) <u>G.</u> (Last) <u>ADAIR</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>7</u> <u>22</u> <u>1955</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH: <u>Nov-4, 1880</u>
9. AGE last birthday: <u>74</u> yrs.		IF UNDER 1 YEAR: <u>8</u> Months <u>18</u> Days	IF UNDER 24 HRS.: <u>18</u> Hours <u>15</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Boiler Inspector U.S. Gov.</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Michigan</u>
13. FATHER'S NAME: <u>John Adair</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Wife- 4417 Bradley Lane, Chevy Ch. Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>491X</u> <u>Bronchopneumonia bilateral</u>		<u>7/15/55 - 7/22/55</u>	
ANTECEDENT CAUSE (B) <u>Senility - generalized arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>July 7, 1955</u> to <u>July 22, 1955</u> , that I last saw the deceased alive on <u>July 21, 1955</u> , and that death occurred at <u>10:55 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Frank A. Gray, Jr.</u>		M. D. <u>104 Cherry Chase Dr. C. M. M. 7/22/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-25-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem.</u>		LOCATION (City, town, or county) <u>Washington D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-28-55</u>		REGISTRAR'S SIGNATURE <u>Beaumont Thompson</u>	
24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 26 1955

RECEIVED

6760

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08768

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 223-

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>Takoma Park</u>		TOWN <u>Chevy Chase</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Sanitarium & Hospital</u>		STREET ADDRESS (If rural, give location)	
		<u>29 W. Irving St</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Susan</u>	(Middle) <u>-</u>	(Last) <u>Alburtis</u>	(Month) <u>July</u> (Day) <u>11</u> (Year) <u>1955</u>
(Type or Print)			
5. SEX: <u>Fe</u>	6. COLOR OR RACE: <u>Wh.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>9-14-1865</u>
			9. AGE last birthday: <u>89</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Summer Camp Director - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY:	
		11. BIRTHPLACE (State or foreign country): <u>District of Columbia</u>	
13. FATHER'S NAME: <u>Edward N. Sipe</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
		17. INFORMANT & ADDRESS: <u>Hosp. Chart</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME: <u>Emma Bender</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Coronary Thrombosis</u>			1 hr.
Antecedent cause(s) (b) <u>Generalized arterio-sclerosis</u>			10 yrs.
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <u>7-11-55</u>		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Frank J. Broschaut</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-11-55</u>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removal</u>		DATE THEREOF <u>7-14-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Dakhill</u>		LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>	
DATE REC'D BY LOCAL REG. <u>July 11-1955</u>		24. FUNERAL DIRECTOR <u>Pheng Chao F. H.</u> ADDRESS <u>5103 W. W. Wash. D.C.</u>	
REGISTRAR'S SIGNATURE <u>J. William Loid</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3.

JUL 19 1955

RECEIVED

6799

06709

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 218

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write OR and give nearest town) <u>Gaithersburg</u>		RURAL LENGTH OF STAY (in this place) <u>50A</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Gaithersburg (rural)</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Diamond Ave</u>				STREET ADDRESS (If rural, give location) <u>Rt 2</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Jackie Andrew Arnold Jr</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>7-7-55</u>			
6. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>7-7-31</u>	
9. AGE last birthday: <u>24</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired): <u>City Work Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Laskie Arnold</u>				14. MOTHER'S MAIDEN NAME: <u>Mable Mc Mahon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		(If Yes, give war or dates of service): <u>Jaeger in Korea</u>		16. SOCIAL SECURITY No.: <u>220-285681</u>		17. INFORMANT & ADDRESS: <u>Washington Drive Md</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Cerebral hemorrhage</u>				DUE TO			
Antecedent cause(s) (b) <u>Compound fracture of skull</u>				DUE TO			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		19c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>highway</u>		21c. (City or town) (County) (State): <u>Gaithersburg Montg 15 md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>7-7-55 11:50 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Driver of auto which struck right side</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE: <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-8-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>July 10 1955</u>		NAME OF CEMETERY OR CREMATORY: <u>Lanier Oak</u>		LOCATION (City, town, or county) (State): <u>Gaithersburg md</u>	
DATE REC'D BY LOCAL REG.: <u>July 9, 1955</u>		REGISTRAR'S SIGNATURE: <u>Alvin L. Goble</u>		24. FUNERAL DIRECTOR: <u>Ref W. Barber Koptonsville</u>		ADDRESS: <u>2mg</u>	

MARGIN RESERVED FOR BINDING

VS. A15A-5-53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 12 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6791

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY _____ MARYLAND		CITY (If outside corporate limits, write RURAL OR and give nearest town) _____ TOWN _____		STATE _____ COUNTY _____		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN _____	
HOSPITAL OR INSTITUTION OR STREET ADDRESS _____		LENGTH OF STAY (in this place) _____ 7 years		STREET ADDRESS _____ (If rural give location)		_____	
3. NAME OF DECEASED: (First) _____ (Middle) _____ (Last) _____				4. DATE (Month) _____ (Day) _____ (Year) _____			
5. SEX: _____				6. COLOR OR RACE: _____			
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): _____				8. DATE OF BIRTH: _____			
9. AGE last birthday _____ yrs.				10. IF UNDER 1 YEAR: Months _____ Days _____			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): _____				10B. KIND OF BUSINESS OR INDUSTRY: _____			
11. BIRTHPLACE (State or foreign country): _____				12. CITIZEN OF WHAT COUNTRY? _____			
13. FATHER'S NAME: _____				14. MOTHER'S MAIDEN NAME: _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) _____				16. SOCIAL SECURITY NO. _____			
17. INFORMANT & ADDRESS: _____				_____			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
(A) IMMEDIATE CAUSE				Congestive Heart Failure			
(B) ANTECEDENT CAUSE (S)				Acute Coronary Thrombosis			
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				Hypertensive Coronary Heart disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				Arterial Thrombosis & Left Hemiplegia (old)			
19A. DATE OF OPERATION: _____				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from July 14, 1955, to July 18, 1955, that I last saw the deceased alive on July 18, 1955, and that death occurred at 11:45 P.M. from the causes and on the date stated above.							
SIGNATURE _____		ADDRESS _____		DATE SIGNED _____			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) _____		DATE THEREOF _____		NAME OF CEMETERY OR CREMATORY _____		LOCATION (City, town, or county) (State) _____	
DATE REC'D BY LOCAL REGISTRAR _____		REGISTRAR'S SIGNATURE _____		24. FUNERAL DIRECTOR _____		ADDRESS _____	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6799 CERTIFICATE OF DEATH

08771
Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda, Chevy Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS <u>4403 Elm St.</u>	(If rural give location)
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>ANDREW</u>	(Middle) <u>S.</u>	(Last) <u>BAIN</u>	OF DEATH: <u>July 1, 19 55</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Aug. 13, 1892</u>
		9. AGE last birthday <u>62</u> yrs.	10. IF UNDER 1 YEAR Months <u>10</u> Days <u>18</u> Hours <u></u> Min. <u></u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Sales Representative-Chicago Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Washington, D. C.</u>	
13. FATHER'S NAME: <u>Andrew M. Bain</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
14. MOTHER'S MAIDEN NAME: <u>Alice Davies</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>577-05-8267</u>	
17. INFORMANT & ADDRESS: <u>Leah S. Bain- Wife</u> <u>4403 Elm St, Chevy Chase, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<u>443X</u>			
IMMEDIATE CAUSE (A) <u>Uremia (UREMIC poisoning)</u>			<u>10 days</u>
ANTECEDENT CAUSE (B) <u>Hypertensive Heart Disease</u>			<u>5 yrs</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 1950</u> , to <u>June 1955</u> , that I last saw the deceased alive on <u>June 30, 1955</u> , and that death occurred at <u>5:30 A M.</u> from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>7/2/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-5-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/2/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Hounston</u>	
24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A11 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CONCLUSION

3 1955

68 0

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Pr. Geo.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Glassmanor</u> <u>16X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Hospital</u>		STREET ADDRESS (If rural give location) <u>217 Hampton Street</u> ✓	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Baby Girl</u> <u>BALAWAG</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>July</u> <u>2</u> <u>1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Malayan</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>SINGLE</u>	8. DATE OF BIRTH: <u>7-1-55</u>
9. AGE last birthday: <u>1</u> yrs.		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>NONE</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Pedro Baccay BALAWAG</u>		14. MOTHER'S MAIDEN NAME: <u>Socorro ZIPAGAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>7</u> No		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT & ADDRESS: <u>Father: Pedro V. BALAWAG 217 Hampton St. Glassmanor, Maryland</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>763.0 Suspected Interstitial</u>			
ANTECEDENT CAUSE (S) <u>Pneumonia</u>		<u>10 min.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Term infant born by Caesarian section</u>			
19A. DATE OF OPERATION: <u>7-1-55</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1 July</u> , 19 <u>55</u> , to <u>2 July</u> , 19 <u>55</u> that I last saw the deceased alive on <u>2 July</u> , 19 <u>55</u> , and that death occurred at <u>12:45 A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>W. S. Mathews, M.D.</u>		ADDRESS <u>DATE SIGNED</u>	
W.S. MATHEWS, LCDR MC USN U.S. Naval Hospital, NNMC, Bethesda, Md.		<u>7-3-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6 July 55</u>	
NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-3-55</u>		REGISTRAR'S SIGNATURE <u>Robert A. Maffingly</u>	
FUNERAL DIRECTOR'S ADDRESS <u>131 11th St. Washington, D.C.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct **mg** is especially important. Physicians: please write the causes of death clearly and legibly.

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1913-1914

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06773

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Silver Spring</u>	<u>4 yrs. apx.</u>	TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9401 Woodland Drive</u>		STREET ADDRESS (If rural give location)	<u>9401 Woodland Drive</u>
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
<u>Charles Turner Barber</u>		OF DEATH: <u>July 28</u> <u>19 55</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDDED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>April 13, 1904</u>
9. AGE last birthday: <u>51</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): <u>Salesman--R.P. Andrews Paper Co.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Forest Glen, Md.</u>	
11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William S. Barber</u>		14. MOTHER'S MAIDEN NAME: <u>Sarah Turner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-09-9502</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Vera N. Barber, 9401 Woodland Dr., SS., Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>		<u>5 minutes</u>	
ANTECEDENT CAUSE (B) <u>Arteriosclerosis</u>		<u>5 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Diabetes Mellitus</u>		<u>5 years</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) (Minute) (Second) (M.)		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>June 10, 1950</u> , to <u>July 28, 1955</u> , that I last saw the deceased alive on <u>July 28</u> , 1955, and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>George B. Patrick</u>		DATE SIGNED <u>7-28-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	
DATE THEREOF <u>Aug. 1, 1955</u>		LOCATION (City, town, or county) <u>Montgomery County, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-31-55</u>		REGISTRAR'S SIGNATURE <u>Frances Tetter</u>	
FUNERAL DIRECTOR <u>Warner E. Pumphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6802
CERTIFICATE OF DEATH

06774

Reg. Dist. No. 215

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u> OR TOWN <u>Bethesda Rural</u> LENGTH OF STAY (in this place) <u>4 mos 17 days</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>		STATE <u>Virginia</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u> OR TOWN <u>Alexandria</u> STREET ADDRESS (If rural give location) <u>334 N. Columbus Street</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last) <u>Gust</u> (N) <u>BARKES</u>		OF DEATH: <u>July</u> <u>2</u> <u>19 55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>5-2-92</u>
9. AGE last birthday		10. BIRTHPLACE (State or foreign country):	
<u>63 yrs.</u>		<u>Greece</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Greece</u>		<u>U.S.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Jimmy BARKES</u>		<u>Lena (Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>Yes</u> <u>WW I</u>		<u>Unknown</u>	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
<u>Friend Mrs. Billie FREEMAN</u> <u>334 N. Columbus Street, Alexandria, Va.</u>		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>199.8</u> IMMEDIATE CAUSE (A) <u>Pulmonary Metastases of Carcinoma</u> ANTECEDENT CAUSE (B) <u>Squamous Cell Ca Esophagus + Benign Prostate</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C)	
19. DATE OF OPERATION:		20. AUTOPSY?	
19a. MAJOR FINDINGS OF OPERATION		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>15 Feb., 1955</u> , to <u>2 July, 1955</u> , that I last saw the deceased <u>alive on 2 July, 1955</u> , and that death occurred at <u>9:08 PM</u> , from the causes and on the date stated above.			
S. D. <u>BOND</u> CDR MC USN U. S. Naval Hospital, NMHC, Bethesda, Maryland		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Arlington National</u>	
DATE REC'D BY LOCAL REGISTRAR		LOCATION (City, town, or county) (State)	
<u>7-3-55</u>		<u>Arlington, Virginia</u>	
REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>Mary E. Casselty</u>		<u>Chambers Funeral Home</u> <u>517 11th St. Washington, D.C.</u>	



13-1-1951

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06775

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH. COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL) <u>Olney</u> LENGTH OF STAY (in this place) TOWN <u>Olney</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sharon Nursing Home</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Burtonsville</u> STREET ADDRESS (If rural give location) <u>7</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Nathan Francis Beall, Jr.</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>July 26 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH: <u>8/26/79</u>	
9. AGE last birthday: <u>75</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Brakeman</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Railroad</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Nathan Francis Beall, Sr.</u>				14. MOTHER'S MAIDEN NAME: <u>Marceline Burton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Hospital Record</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Congestive heart failure, chronic</u>						<u>1 1/2 months</u>	
ANTECEDENT CAUSE (B) <u>Chronic myocarditis</u>						<u>1 yr</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 1952, to <u>July</u> , 1955, that I last saw the deceased alive on <u>7/25</u> , 1955, and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Nathan Francis Beall, Jr.</u>		M. D. <u>Imelda Sping, M.D.</u>		DATE SIGNED <u>7/27/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 29-55</u>		NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		LOCATION (City, town, or county) (State) <u>Burtonsville Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-28-55</u>		REGISTRAR'S SIGNATURE <u>Imelda B. Lawley</u>		24. FUNERAL DIRECTOR <u>Herbert Romadsky</u>		ADDRESS <u>Burtonsville Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUTLER V. E.

AUG 2 1955

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06576

68 4

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Ind</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town).	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
56 TOWN <u>Silver Spring</u>		OR TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2714 Arvin St.</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:	(First) (Middle) (Last)	4. DATE OF DEATH:	(Month) (Day) (Year)
(Type or Print) <u>Karen Lee Bean</u>		<u>July 7, 1955</u>	
5. SEX. <u>Female</u>	6. COLOR OR RACE. <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>single</u>	8. DATE OF BIRTH <u>5/28/1949</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Child</u>	10B. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday, IF UNDER 1 YEAR	IF UNDER 24 HRS. Months Days Hours Min.
		<u>6 yrs</u>	
13. FATHER'S NAME: <u>Jackson Bryan Bean</u>	14. MOTHER'S MAIDEN NAME: <u>Norberta Bramell</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT & ADDRESS: <u>Father - 2714 Arvin St</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Acute Cardiac Arrest</u>			<u>intense</u>
ANTECEDENT CAUSE (S) (B) <u>Congenital Heart Defect</u>			<u>life</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Congenital Heart Disease</u>			<u>life</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Non-pneumonia</u>			<u>3 days</u>
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Spring, 1952</u> to <u>July 7, 1955</u> ; that I last saw the deceased alive on <u>July 5, 1955</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Francis J. Bean - Lee</u>		ADDRESS <u>M.D. 527 Pershing Dr. Silver Spring, Md</u>	DATE SIGNED <u>7/7/55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>7/11/55</u>	NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	LOCATION (CITY, COUNTY, STATE) <u>Prince George Co., Maryland</u>
DATE REC'D BY LOCAL REGISTRAR <u>7-11-55</u>	REGISTRAR'S SIGNATURE <u>Francis J. Bean</u>	24. FUNERAL DIRECTOR <u>Warner L. Humphrey</u>	ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

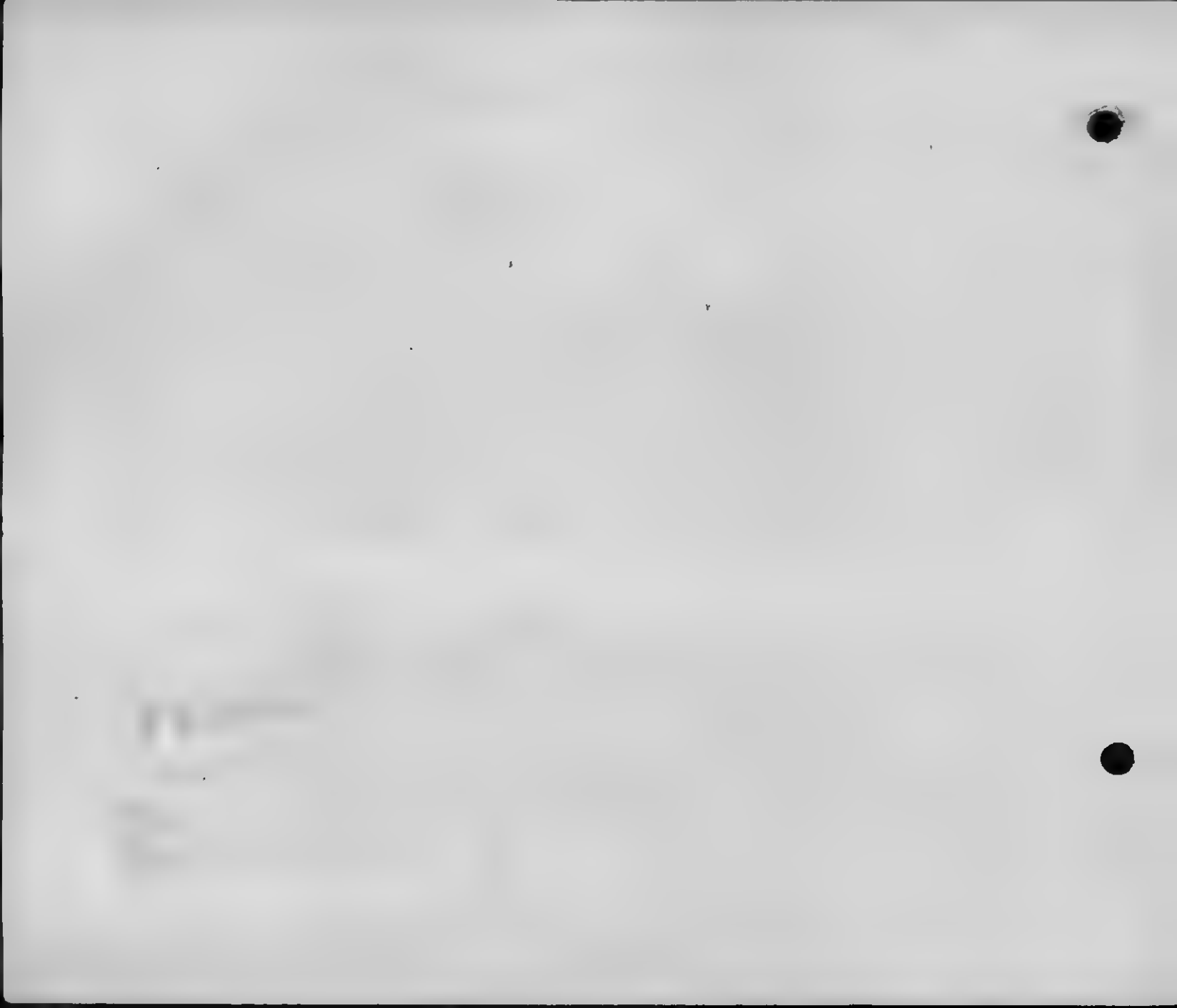
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Montgomery</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits write RURAL OR and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) <u>Silver Spring</u>		OR TOWN <u>F6</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural, give location) <u>Rt 2, Hollywood</u>			
3. NAME OF DECEASED: (Type or Print) <u>Walter K. Bennett</u>				4. DATE OF DEATH <u>July 8 1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>S</u>		8. DATE OF BIRTH: <u>7 1905</u>	
9. AGE last birthday: <u>50</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Invalid</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	
13. FATHER'S NAME: <u>W. E. Bennett</u>				14. MOTHER'S MAIDEN NAME: <u>Otha Copenhaver</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>1</u>		16. SOCIAL SECURITY No.: <u>1</u>		17. INFORMANT & ADDRESS: <u>Charles K. Bennett (Brother) (same address)</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
450.0 Immediate cause (a) <u>Congestive Heart failure</u>						several days	
Antecedent cause(s) (b) <u>Atherosclerosis, severe, coronary</u>						yrs?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>hypertension</u>						yrs?	
19a. DATE OF OPERATION: <u>2</u>						19b. MAJOR FINDING OF OPERATION: <u>Bronchopneumonia, bilateral</u>	
19c. DATE OF OPERATION: <u>2</u>						20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>John W. Ball</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>8 July 55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>July 12, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Wilmington National Cemetery, Fort Myer, Va.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>7-11-55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Wanner Co. Humphrey, Silver Spring, Md.</u>			



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08778

6770

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>md.</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Takoma Park,</u>	LENGTH OF STAY (in this place) <u>2 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. San. & hosp.</u>		STREET ADDRESS (If rural give location) <u>71512 Piney Branch rd.</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH:	
(First) <u>Berlin</u> (Middle) <u>Brathway</u> (Last) <u>Biller</u>		(Month) <u>7</u> (Day) <u>21</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>9-12-21</u>
		9. AGE last birthday <u>33</u> yrs.	10. IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Mechanic</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Esso</u>	11. BIRTHPLACE (State or foreign country): <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME: <u>Lewis F. Biller</u>	
14. MOTHER'S MAIDEN NAME: <u>Annie E. Miller</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY No. <u></u>		17. INFORMANT & ADDRESS: <u>Wife - Same</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Acute Hepatitis</u>			<u>4 weeks</u>
ANTECEDENT CAUSE (B) <u>Laennee Cirrhosis</u>			<u>1 yr. approx</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>None</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION. <u></u>		19B. MAJOR FINDINGS OF OPERATION <u></u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 17, 1955</u> to <u>July 21, 1955</u> , that I last saw the deceased alive on <u>July 21, 1955</u> , and that death occurred at <u>9:50 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Ralph F. Catter</u>		ADDRESS <u>Silver Spring</u> DATE SIGNED <u>July 21, 55</u>	
M. D. <u>8644 Colanville Rd.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>July 22, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. Jackson, Shenandoah Co., Va.</u>		LOCATION (City, town, or county) (State) <u>Silver Spring, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>July 22, 1955</u>		REGISTRAR'S SIGNATURE <u>J. Walter Dodd</u>	
24. FUNERAL DIRECTOR'S ADDRESS <u>Silver Spring, Md.</u>			

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1965

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6816
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>District of Columbia</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X <u>Bethesda Rural</u>		<u>20 Hr 28 Min</u>		<u>Washington, D.C.</u> <u>47 Y. 2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>U. S. Naval Hospital</u>				<u>20 Logan Circle N.W.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		OF DEATH			
<u>Baby</u> <u>Girl</u> <u>BLACKWELL</u>		<u>July 14</u> <u>1955</u>					
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>Negroid</u>	<u>Single</u>	<u>7-13-55</u>	<u>20</u> yrs	<u>Months</u>	<u>Days</u>	<u>Hours</u> <u>Mins.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
						<u>Bethesda, Maryland</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME:			
<u>Henry Robert BLACKWELL</u>				<u>Shirley Romaine HOLDEN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO			
<u>No</u>				<u>None</u>			
17. INFORMANT & ADDRESS:				18. MEDICAL CERTIFICATION			
<u>Father Henry Robert BLACKWELL</u>				<u>Same as above</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE				<u>20hr 28"</u>			
ANTECEDENT CAUSE (S)				<u>20hr 28"</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>13 July, 1955</u> , to <u>14 July, 1955</u> , that I last saw the deceased alive on <u>14 July, 1955</u> , and that death occurred at <u>6:00 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>W. S. Matthews, M.D.</u>				DATE SIGNED <u>7-15-55</u>			
V.S. MATTHEWS LCDR MC USN U.S. Naval Hospital, NMMC, Bethesda, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-17-55</u>		<u>Lottsburg Cemetery Northumbland County, Lottsburg, Va.</u>			
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7-14-55</u>		<u>Henry S. Washington</u>		<u>467 N. ST. N.W.</u>		<u>Washington, D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06700

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Mont</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Mont.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
X TOWN <u>Bethesda</u>	<u>1 hour</u>	<u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>74 Suburban</u>		<u>4408 Gridley Rd.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH	
<u>Ellen Ann Blanchard</u>		<u>July 13 1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>Sept. 3, 1886</u>
9. AGE last birthday		IF UNDER 1 YEAR Months Days	
<u>68</u> yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
<u>Housewife</u>		<u>Own Home</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Lancaster, England</u>		<u>U.S.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>John B. Butterworth</u>		<u>Elizabeth Ann Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO	
<u>No</u>		<u>None</u>	
17. INFORMANT & ADDRESS:			
<u>Elmer F. Blanchard, Silver Spring, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A)		<u>1 hour</u>	
<u>420.1</u>			
ANTECEDENT CAUSE (B)		<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1953</u> , to <u>7/13/55</u> , that I last saw the deceased alive on <u>7/13/55</u> , and that death occurred at <u>10:45</u> P.M. from the causes and on the date stated above.			
SIGNATURE <u>Elmer F. Blanchard</u>		DATE SIGNED <u>7/13/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
<u>Ship & burial</u>		<u>St. Ann's Cemetery</u>	
DATE THEREOF <u>July 16, 1955</u>		LOCATION (City, town, or county) (State) <u>Cranston, Rhode Island</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-16-55</u>		24. FUNERAL DIRECTOR ADDRESS <u>Silver Spring, Md.</u>	
REGISTRAR'S SIGNATURE <u>Seaside M. Thompson</u>			

1. A. 1950

1950

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06781

68'8

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH: <u>Suburban Hospital,</u>		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY: <u>Montgomery</u>	MARYLAND	STATE: <u>Md.</u>	COUNTY: <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town): <u>Bethesda</u>	LENGTH OF STAY (In this place): <u>51 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: <u>Bethesda, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS: <u>Suburban Hospital, Bethesda, Md.</u>		STREET ADDRESS: <u>8150 Rockville Pike</u>	
3. NAME OF DECEASED: (Type or Print) <u>Sierra Anne Blundon</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July 4, 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>July 16, 1883</u>
9. AGE last birthday: <u>72</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Dallas Tx. Va.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. FATHER'S NAME: <u>Aggleson (?)</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>No.</u>		14. SOCIAL SECURITY NO.: <u>X.</u>	
15. MOTHER'S MAIDEN NAME: <u>Laura Finney</u>		16. INFORMANT & ADDRESS: <u>Earl A. Blundon, 9 Rockville Pike, Silver Spring, Md.</u>	
17. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Acute myocardial infarction</u>		<u>3 days (?)</u>	
ANTECEDENT CAUSE (B) <u>Coronary artery thrombosis</u>		<u>3 days (?)</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Coronary atherosclerosis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>hypertension</u>			
18. DATE OF OPERATION: <u>None</u>		19. MAJOR FINDINGS OF OPERATION:	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 4, 1955</u> , to <u>July 4, 1955</u> , that I last saw the deceased alive on <u>July 4, 1955</u> , and that death occurred at <u>7:35 P.M.</u> from the causes and on the date stated above.			
SIGNATURE: <u>Robert A. Humphrey</u>		DATE SIGNED: <u>1/4/55</u>	
M.D. <u>Robert A. Humphrey</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Cremation</u>		24. FUNERAL DIRECTOR ADDRESS: <u>Robert A. Humphrey Bethesda Md</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>7/6/55</u>		REGISTRAR'S SIGNATURE: <u>Bessie M. Thompson</u>	
25. DATE OF DEATH: <u>July 4, 1955</u>		26. PLACE OF DEATH: <u>Suburban Hospital, Bethesda, Md.</u>	

BRUNNEN V. S.

1911



CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY MONTGOMERY		MARYLAND		STATE Florida		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN Bethesda Rural		1 Mo 4 days		TOWN Jacksonville		43 X-1	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital, NMMC, Bethesda 14, Maryland				STREET ADDRESS (If rural give location) 5145 Birkenhead Road			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
Robert Dalton BLYTH				July 28 1955			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Male		Cauc.		Married		25 OCT 1908	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Mariner		Mariner Retired		Colorado		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Robert (n) BLYTH				Vyrna DAVIS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
				Unknown		Jacksonville, Fla. Olive S. BLYTH, 5145 Birkenhead Rd.,	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 204.1 Leukemia, chronic, myelogenous						2 yrs.	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Shock, postoperative						4 hrs.	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7-28-55		Splanomegaly, extreme.					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 25 July, 1955 , to 28 July, 1955 that I last saw the deceased alive on 28 July 1955 and that death occurred at 2:20 PM , from the causes and on the date stated above.							
SIGNATURE M. L. GERBER				ADDRESS U.S. Naval Hospital, NMMC, Bethesda, Maryland		DATE SIGNED 7-28-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Cremation		29 JULY 1955		Ceder Hill		Suitland, Prince Georges Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR			
7-28-55		Mary E. Sawally		R. A. Humphrey Funeral Home 7557 Wisconsin Avenue, Bethesda, Md.			

MARGIN RESERVED FOR BINDING

BUNDOU V. S.

AUG 1 19

1954

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2, 3, 13 Filing 184 8-4-55 et

06783

8,13: 681091 8-3-55

CERTIFICATE OF DEATH

Reg. Dist. No. 210

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED: Cumberland	
COUNTY <u>Montgomery</u> MARYLAND	STATE <u>Pa.</u> COUNTY <u>HARRISBURG</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Camp Hill</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bedford</u>	STREET ADDRESS (If rural give location) <u>2907 Chestnut St.</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Mrs. Alice Bohn</u>		<u>July 18 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>869</u> 9. AGE last birthday <u>86</u> yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>	
10C. KING OF BUSINESS OR INDUSTRY:		12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	
13. FATHER'S NAME: <u>JAMES F. Armstrong</u>		14. MOTHER'S MAIDEN NAME: <u>Infield</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Mrs. Mary P. Lee, 10605 Wheatley St, Kensington (Md)</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Senile Cerebral</u>			<u>acute</u>
ANTECEDENT CAUSE (S) <u>Hypertension</u>			<u>4 yrs</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerosis</u>			<u>yr</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21B. PLACE (Home, farm, factory or injury street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7/13/55</u> 19... to <u>7/18/55</u> 19... that I last saw the deceased alive on <u>7/17/55</u> and that death occurred at <u>11: A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		ADDRESS <u>1600 CHAMBERS ST</u>	
23. DATE REC'D BY LOCAL REGISTRAR <u>7-20-55</u>		24. FUNERAL DIRECTOR ADDRESS <u>N.W. 1400 CHAMBERS ST</u>	
25. DATE THEREOF <u>7/18/55</u>		26. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	
27. LOCATION (City, town, or county) <u>Suitland</u>		(State) <u>M.D.</u>	

THE NEW YORK

1905

1905

6811

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda Rural</u> LENGTH OF STAY (in this place) <u>3 hr 30 min</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hosrital</u>		STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda Rural</u> STREET ADDRESS (If rural give location) <u>U. S. Naval Hospital</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Baby Girl BREEDLOVE</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July 4 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Negroid</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>7-4-55</u>
9. AGE last birthday		10. CITIZEN OF WHAT COUNTRY?	
yrs. Months Days Hours Min.		<u>U. S.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
		<u>Maryland</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Maryland</u>		<u>U. S.</u>	
13. FATHER'S NAME: <u>William BREEDLOVE</u>		14. MOTHER'S MAIDEN NAME: <u>Iola Patricia SANDERS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
<u>No</u>		17. INFORMANT & ADDRESS: <u>Mother Iola P. BREEDLOVE</u> <u>4907 7th Street, N.W., Wash., D.C.</u>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<u>3 hrs 33 min</u>	
(A) IMMEDIATE CAUSE <u>Prematurity at 16 weeks</u>			
(B) ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
M.		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>4 July, 1955</u> , to <u>4 July, 1955</u> that I last saw the deceased alive on <u>4 July, 1955</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>W. S. Matthews, M.D.</u>		DATE SIGNED	
W. S. MATTHEWS LCDR MC USN U. S. Naval Hospital, NIMC, Bethesda, Maryland			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Arlington National Arlington, Va.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-5-55</u>		24. FUNERAL DIRECTOR ADDRESS	
REGISTRAR'S SIGNATURE <u>Mary E. Casselty</u>			

MARGIN RESERVED FOR BINDING

VS. A15-10-53

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. AIR FORCE

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 223

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write, RURAL and give nearest town)	
TOWN <u>Shiloh Park, D. D. A.</u>		TOWN <u>Silver Spring</u>	<u>56</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
<u>Washington Sanatorium & Hosp.</u>		<u>12312 Colesville Rd.</u>	
3. NAME OF DECEASED:	(First) (Middle) (Last)	4. DATE OF DEATH	(Month) (Day) (Year)
(Type or Print)	<u>Dora</u> <u>Wendell</u> <u>Bretz</u>	<u>7-16</u>	<u>1955</u>
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Female</u>	<u>Caucasian</u>	<u>Widow</u>	<u>3-7-26</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.
<u>Retired</u>		<u>79</u> yrs.	Months Days Hours Min.
11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?		
<u>Hamburg, Germany</u>	<u>U.S.C.</u>		
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:		
<u>Fritz Wemmerman</u>	<u>Dorothy</u> <u>Unknown</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:	
<u>No</u>	<u>-</u>	<u>Daughter</u> <u>Fern M. Bean - 12312 Colesville Rd.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause	(a).....	
<u>Coronary occlusion</u>		<u>1 1/2 hrs.</u>
Antecedent cause(s)	(b).....	
Diseases or conditions, if any, giving rise to the above cause	DUE TO	
stating underlying cause last	(c)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>Frank J. Bruch</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-17-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>Ship & burial</u>	<u>July 18, 1955</u>	<u>Loveland Burial Park</u>
LOCATION (City, town, or county) (State)	<u>Loveland, Larimer Co., Colorado</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
<u>July 18-1955</u>	<u>J. L. Tiller & Lodd</u>	<u>Warner & Humphrey 8459 E. Ave. & 1st St.</u>



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06786

6812

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>OR TOWN</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14003 Coltsville Rd. S.S.</u>				STATE <u>MD</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>OR TOWN</u> <u>Silver Spring</u> STREET ADDRESS (If rural give location) <u>631 Ritchie Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Lula W. Burch</u>				<u>7 1 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>W.</u>	<u>4/26/1980</u>	<u>75</u> yrs.	Months <u>2</u> Days <u>5</u>	Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Homemaker</u>						<u>Buckeysville, Md. U.S.A</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>George R. Astlin</u>				<u>Mary M. Matthews</u>			
15. DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS:	
				<u>None</u>		<u>Mrs. Dorothy B. Catalano</u> <u>Silver Spring, Md.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
593X IMMEDIATE CAUSE				(A) <u>uramin. Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
ANTECEDENT CAUSE (S)				(B) <u>hypertension</u>		<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C) <u>chronic arthritis</u>		<u>years</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
						INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>4/1</u> , 1955, to <u>7/1/1</u> , 1955, that I last saw the deceased alive on <u>6/30</u> , 1955, and that death occurred at <u>M</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>7/1/55</u>			
23. BURIAL CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY			
<u>Burial</u>				<u>Monocacy</u>			
DATE REC'D BY LOCAL REGISTRAR				LOCATION (City, town, or county) (State)			
<u>7-1-55</u>				<u>Bellville Md</u>			
REGISTRAR'S SIGNATURE <u>Gertrude B. Lawler</u>				24. FUNERAL DIRECTOR			
				ADDRESS <u>Harmon & Company Silver Spring</u>			

BUREAU V. 24

LL 5 1955

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06787

6313

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montg.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Damascus</u>		Life		TOWN <u>Damascus</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
13. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Franklin Ellsworth Burdette</u>				<u>July 10 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.		
Male	White	Widowed	Sept. 18, 1873	81 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life.		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired Farmer</u>		<u>Own Farm</u>		<u>Damascus, Md.</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Nathan J. Burdette</u>				<u>Rispa Ann Lewis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No:		17. INFORMANT & ADDRESS:			
No.		--		<u>Maxwell E. Burdette, Damascus, Md.</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
61. X Immediate cause (a) <u>Pylonephritis</u>						<u>4 mos.</u>	
Antecedent causes (s) (b) <u>Chronic Prostatitis</u>						<u>years</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Benign Hypertrophy of Prostate</u>						<u>years</u>	
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death. <u>Generalized arteriosclerosis, Mod hypertension</u>							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION					
<u>5/17/55</u>		<u>Benign Hypertrophy of Prostate</u>					
20. AUTOPSY?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		None					
HOMICIDE		INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
		m.					
22. I hereby certify that I attended the deceased from <u>5/12</u> , 19 <u>55</u> , to <u>7/10</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/10</u> , 19 <u>55</u> , and that death occurred at <u>4:25 AM</u> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
<u>Ben J. Meaden M.D.</u>				<u>Boyer Clinic Damascus Md.</u>		<u>7/11/55</u>	
23. BURIAL, CREMATION, REMOVA (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 12, 1955</u>		<u>Damascus</u>		<u>Damascus, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>July 11/1955</u>		<u>Deella W. Burdette</u>		<u>Oliver L. Molesworth, Damascus, Md.</u>			

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CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> TOWN <u>17</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanatorium & Hospital</u> LENGTH OF STAY (in this place) <u>4 days</u>				STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> OR TOWN <u>1</u> STREET ADDRESS (If rural give location) <u>9316 Gaia St</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JAMES</u> (Middle) <u>MC ELFRESH</u> (Last) <u>BUTLER</u>				(Month) <u>JULY</u> (Day) <u>14</u> (Year) <u>1955</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Male		white		Married		1-26-93	
9. AGE last birthday: 62 yrs				10. CITIZEN OF WHAT COUNTRY? Amer - USA			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Cnauffer - retired</u>				10B. KIND OF BUSINESS OR INDUSTRY:			
11. BIRTHPLACE (State or foreign country): <u>Washington, D. C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>Amer - USA</u>			
13. FATHER'S NAME: <u>JAMES I. BUTLER</u>				14. MOTHER'S MAIDEN NAME: <u>ADA MAE YOUNG</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>NO</u> (If Yes, give war or dates of service):				16. SOCIAL SECURITY NO.: <u>Yes-Unavailable</u>			
17. INFORMANT & ADDRESS: <u>MRS. MARY YOUNG - SAME ADDRESS</u>							
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>443X</u> ANTECEDENT CAUSE (S): <u>Cerebral Hemorrhage</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Hypertension</u> <u>Chronic Ischemic Cardiovascular Disease</u>				<u>4 hrs</u> <u>8 hrs</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 14, 1954</u> to <u>July 14, 1955</u> , that I last saw the deceased alive on <u>July 14, 1955</u> , and that death occurred at <u>7:45 PM</u> , from the causes and, on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>		DATE SIGNED <u>July 14, 1955</u>		M. O. <u>[Signature]</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		7/18/55		Ft. Lincoln Cemetery		Prince George County, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
July 16-1955		<u>[Signature]</u>		<u>Warner & Humphrey</u>		8434 Ga. Ave. Silver Spring, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S. A. G. 1110

1985

6814
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 214

I. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write OR and give nearest town) Silver Spring
TOWN 3 yrs.
HOSPITAL OR INSITUATION OR STREET ADDRESS 10104 McKinney Ave

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits write RURAL and give nearest town) 56
OR TOWN Silver Spring
STREET ADDRESS 10,104 McKinney Ave.
(If rural, give location)

3. NAME OF DECEASED: (First) (Middle) (Last)
(Type or Print) Francis P. L. CAPORALE

4. DATE OF DEATH (Month) (Day) (Year)
July 10 19 55

5. SEX: 6. COLOR OR RACE: 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married 8. DATE OF BIRTH: Aug. 27, 1913 9. AGE last birthday: 41 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Radio Engineer 10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't. C.A.A. 11. BIRTHPLACE (State or foreign country): Philadelphia, Pa. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Pasquale A. Caporale

14. MOTHER'S MAIDEN NAME: Adelina Basta

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 17. INFORMANT & ADDRESS: Mr. Wm. Rowen Grant, 307 E. Girard Ave. Philadelphia 25, Pa.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1
Immediate cause (a) Cardiac Arrest DUE TO
Antecedent cause(s) (b) Thrombosis Main left descending Coronary ? hours
Diseases or conditions, if any, giving rise to the above cause DUE TO
stating underlying cause last (c) Atherosclerosis, Coronary ? years

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY 21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 21e. INJURY OCCURRED While at Not while at work ☐ at work ☐ 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE John H. Ball CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 11 July 55
DEPUTY MEDICAL EXAMINER ☐
M. D. ASSISTANT MEDICAL EXAM. ☐

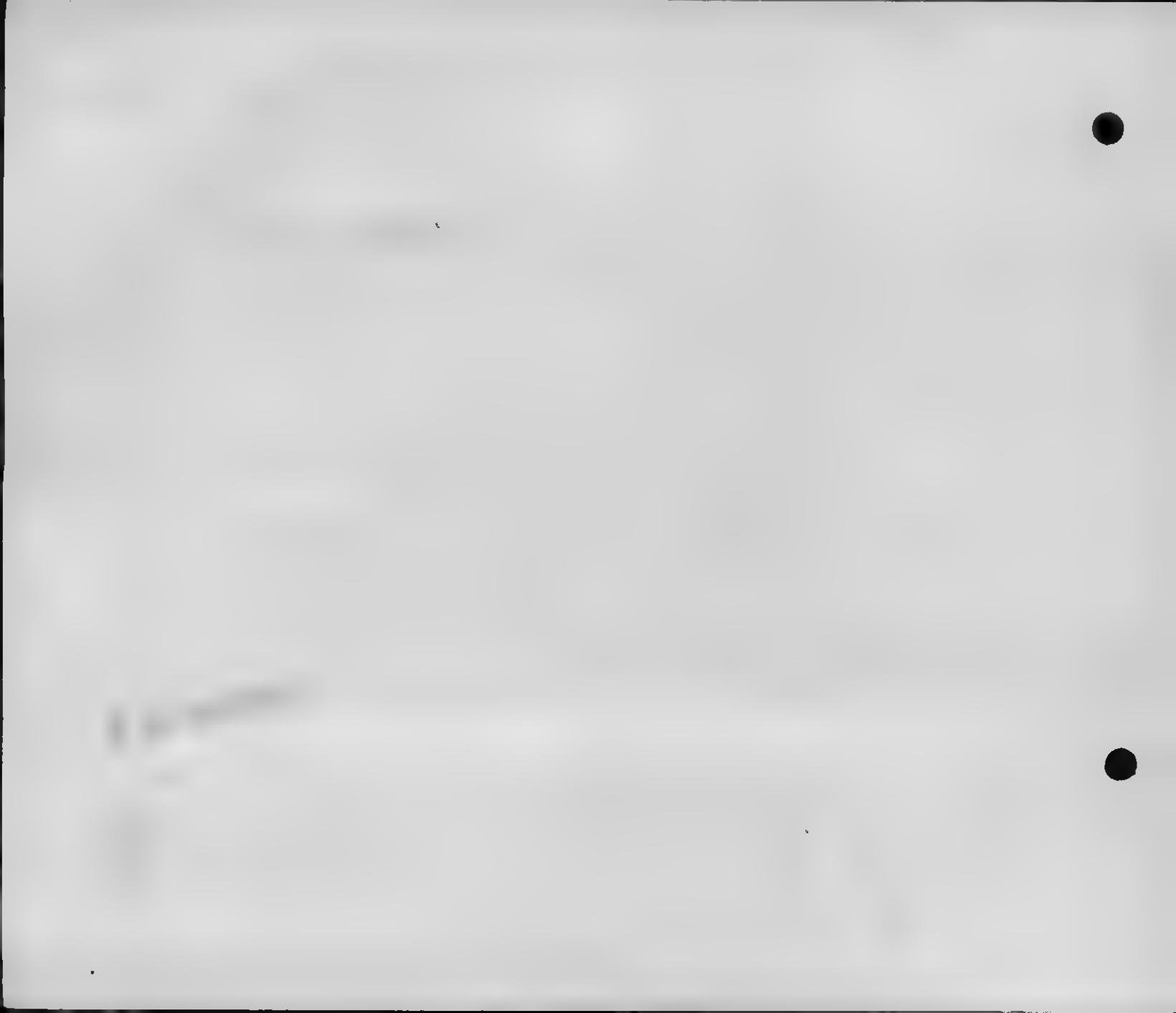
23. BURIAL, CREMATION, REMOVAL (Specify): DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)
Trans. & Burial 7/12/55 Holy Cross Cemetery Yeadon, Pennsylvania

DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS
7-12-55 Francesa Potter Warner E. Humphrey 8434 Ga. Ave. Silver Spring, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A-563



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write OR and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>7-55/7-9-55</u>	CITY (If outside corporate limits write RURAL and give nearest town) <u>Rockville</u>	TOWN <u>Rockville</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural, give location) <u>613 Douglas Ave</u>	
3. NAME OF DECEASED: (First) <u>Mrs. Clara E. Carter</u> (Middle) (Last)		4. DATE OF DEATH (Month) <u>July</u> (Day) <u>19</u> (Year) <u>1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>7/10/01</u>
9. AGE last birthday: <u>54</u> yrs.	10a. USUAL OCCUPATION: (Give kind of work done during most of work life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Washington D.C.</u>
12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	13. FATHER'S NAME: <u>Thomas Johnson</u>	14. MOTHER'S MAIDEN NAME:	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS: <u>William J. Carter Bethesda</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
154X Immediate cause (a) <u>Cor - pulmonale</u> DUE TO		<u>minutes?</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) <u>massive embolus, pulmonary artery</u> DUE TO		<u>minutes?</u>
(c) <u>Thrombus, iliac vein</u>		<u>weeks?</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Carcinoma, sigmoid - rectum</u>		<u>2 1/2 yrs.</u>
19a. DATE OF OPERATION: <u>24 June 55</u>	19b. MAJOR FINDING OF OPERATION: <u>Operable CA sigmoid - rectum</u>	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) <u>Rockville</u> County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>Frank J. Broshant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7/19/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>
23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>7-22-55</u>	NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>
LOCATION (City, town, or county) <u>Rockville, Md.</u>	(State)	
DATE REC'D BY LOCAL REG. <u>7-22-55</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	41. FUNERAL DIRECTOR <u>Robert L. Snowden</u>
		ADDRESS <u>Rockville Md</u>



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06791

6816

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>			
CITY (If outside co. or state limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>Bethesda</u>		<u>168 days</u>		TOWN <u>Brentwood</u>		<u>16-54-</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u> <u>National Institutes of Health</u>				STREET ADDRESS (If rural give location) <u>4404 40th St.</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) <u>Jane</u>		(Middle) <u>--</u>		(Last) <u>Cestone</u>		(Month) (Day) (Year) <u>July 15, 1955</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Aug 9, 1901</u>	
9. AGE last birthday <u>53</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>---</u>		11. BIRTHPLACE (State or foreign country): <u>Scotland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Scotland</u> X		13. FATHER'S NAME: <u>Patrick McCairn</u>		14. MOTHER'S MAIDEN NAME: <u>Ellen Donachie</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>		18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>Multiple myeloma</u>							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>June 8, 1955</u>		19b. MAJOR FINDINGS OF OPERATION: <u>Trephining of Skull. Ventriculograms negative.</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>None</u>		21c. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 28, 1955</u> , to <u>July 15, 1955</u> , that I last saw the deceased alive on <u>July 15, 1955</u> , and that death occurred at <u>9:40PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS <u>The Clinical Center</u>		DATE SIGNED <u>July 16, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>19 July 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		LOCATION (City, town, or county) (State) <u>Colmar Manor, MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-16-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Walters Funeral Home Inc.</u>		ADDRESS <u>3200 E. Island Ave.</u>	



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CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda</u> Rural <u>33</u> days HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>		STATE <u>District of Columbia</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington, D.C.</u> 47X- STREET ADDRESS (If rural give location) <u>229 E Street, N.W.</u> ✓	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) (Middle) (Last) <u>William Russell CLATTERBUCK</u>		(Month) (Day) (Year) <u>July 24 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>1-13-88</u>
9. AGE last birthday		10. KIND OF BUSINESS OR INDUSTRY:	
<u>67</u> yrs.		<u>-----</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Virginia</u>		<u>U. S.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Ben CLATTERBUCK</u>		<u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>Yes</u> <u>WW1</u>		<u>Unknown</u>	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
<u>Wife Roberta CLATTERBUCK</u> <u>Same as above</u>		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>4-20-1</u> IMMEDIATE CAUSE (A) <u>Infarction, Myocardial</u> ANTECEDENT CAUSE (B) <u>CORONARY OCCLUSION</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>CORONARY ATHEROSCLEROSIS</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>-----</u>		<u>-----</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
<u>-----</u>		<u>1 hr.</u> <u>? yrs</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
<u>-----</u>		<u>-----</u>	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
<u>-----</u>		<u>-----</u>	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
<u>-----</u>		<u>-----</u>	
22. I hereby certify that I attended the deceased from <u>21 June 1955</u> to <u>24 July 1955</u> that I last saw the deceased alive on <u>24 July 1955</u> , and that death occurred at <u>4:00A</u> M, from the causes and on the date stated above.			
SIGNATURE OF REGISTRAR		DATE SIGNED	
<u>W. B. INGRAM</u>		<u>-----</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. FUNERAL DIRECTOR	
<u>Burial</u>		<u>Chambers Funeral Home</u>	
DATE REC'D BY LOCAL REGISTRAR		ADDRESS	
<u>7-24-55</u>		<u>517 11th St., Washington, D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU

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C819

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY <u>Bellevue Spring</u> OR <u>Bellevue Spring</u> TOWN	LENGTH OF STAY (in this place)	CITY <u>Bellevue Spring</u> OR <u>Bellevue Spring</u> TOWN	(If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>514 Lighthouse Drive</u>		STREET ADDRESS <u>514 Lighthouse Drive</u>	
3. NAME OF DECEASED: (Type or Print) <u>Claxton, William Thomas</u>		4. DATE OF DEATH <u>July 17 1955</u>	
5. SEX: <u>Fe</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Mar.</u>	8. DATE OF BIRTH: <u>April 23-1879</u>
9a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	9. AGE last birthday: <u>76</u> Yrs. <u>2</u> Mo. <u>24</u> Days
10. FATHER'S NAME: <u>George Johnson</u>		11. BIRTHPLACE (State or foreign country): <u>Massachusetts</u>	
12. MOTHER'S MAIDEN NAME: <u>Maynard Payne</u>		13. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>No</u>		15. SOCIAL SECURITY NO.: <u>No. Beland 3 Claxton Stem #2</u>	
16. INFORMATION & ADDRESS: <u>No. Beland 3 Claxton Stem #2</u>		17. INFORMATION & ADDRESS: <u>No. Beland 3 Claxton Stem #2</u>	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Right Heart failure</u>		<u>3 hours</u>
Antecedent causes (b) <u>Hypertension, edema</u>		<u>1 year</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY ? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

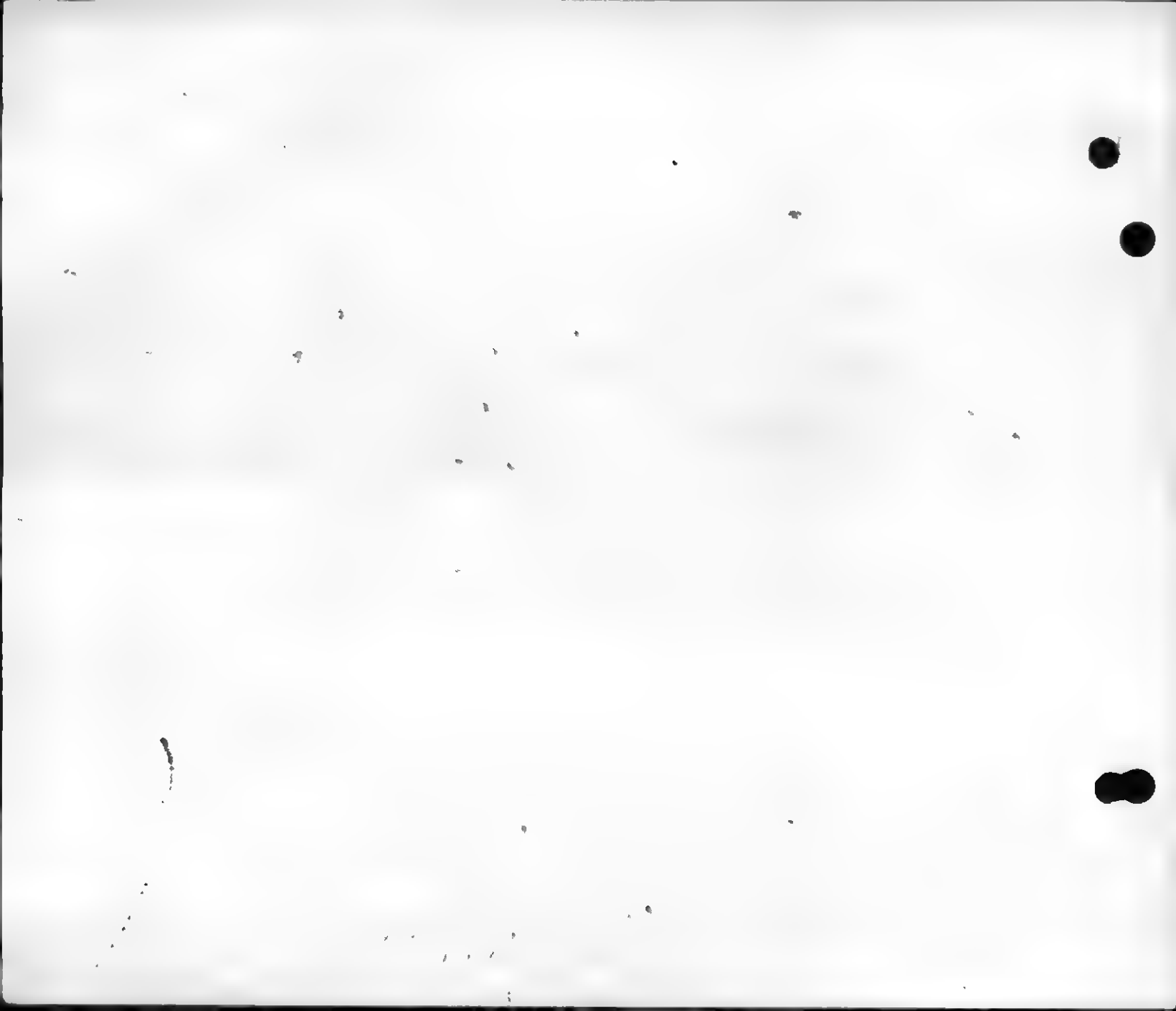
22. I hereby certify that I attended the deceased from Aug, 1954, to July 17, 1955, that I last saw the deceased
alive on July 17, 1955, and that death occurred at 12:30 A.M. from the causes and on the date stated above.

SIGNATURE <u>John A. Andrews M.D.</u>		DATE SIGNED <u>7-17-55</u>	
(Degree or title)		ADDRESS <u>9601 Collesville Rd. Silver Spring Md</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF <u>July 17-1955</u>	NAME OF CEMETERY OR CREMATORY <u>Highland Park</u>	LOCATION (City, town, or county) (State) <u>Theriotville Tenn</u>
DATE REC'D BY LOCAL REGISTRAR <u>7-18-55</u>	REGISTRAR'S SIGNATURE <u>Frances Foster</u>	24. FUNERAL DIRECTOR <u>Robert A. Pumphrey - E.F.D.</u>	ADDRESS <u>Bethesda Md</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The report is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5820 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9, Film 184 8-1-55 et

06796

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		STATE <u>Virginia</u>		COUNTY <u>Fairfax</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Bethesda Rural</u>		OR TOWN <u>Fairfax</u>		OR TOWN <u>Fairfax</u>		83 X - 2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)		STREET ADDRESS (If rural give location)			
<u>U. S. Naval Hospital</u>		<u>Rt. # 2, Box 56</u>		<u>Rt. # 2, Box 56</u>		✓	
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Mary Jewel CLUTE</u>				<u>July 24 19 55</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>10-3-19</u>	
9. AGE last birthday <u>35</u> yrs.		IF UNDER 1 YEAR: Months Days		IF UNDER 24 HRS: Hours Mins.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Housewife</u>			
11. BIRTHPLACE (State or foreign country): <u>California</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME: <u>Daniel HAYES</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>No</u>				16. SOCIAL SECURITY NO.: <u>Unknown</u>			
17. INFORMANT & ADDRESS: <u>(Husband) George S. CLUTE, Same as above</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Hepatic Failure</u>						<u>1 week</u>	
ANTECEDENT CAUSE (B) <u>Cirrhosis of the Liver</u>						<u>unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19A. DATE OF OPERATION: <u>7-27-55</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>20 July, 1955</u> , to <u>24 July, 1955</u> , that I last saw the deceased alive on <u>24 July 1955</u> , and that death occurred at <u>6:50 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Gerald J. Giffman</u>				ADDRESS		DATE SIGNED	
<u>G. I. Giffman, U.S. Naval Hospital, Bethesda, Maryland</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial transit</u>		<u>7-27-55</u>		<u>Golden Gate National</u>		<u>San Bruno, California</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7-25-55</u>		<u>Mary E. Carrelly</u>		<u>R. A. Pumphrey Funeral Home</u>		<u>7557 Wisconsin Avenue, Bethesda, Maryland</u>	

S A CREDIT

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4, Film 184 7-20-55 et

CERTIFICATE OF DEATH

Reg. Dist. No.

06707

214

1. PLACE OF DEATH: COUNTY <u>MONTGOMERY</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>FOREST GLEN</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dea. J. Nelson</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD.</u> COUNTY <u>MONTG.</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>FOREST GLEN, SILVER SPRING</u> STREET ADDRESS (If rural give location) <u>1</u>	
3. NAME OF DECEASED: (Type or Print) <u>IDA E. COLE</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July 13, 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH: <u>7-5-1866</u>
9. AGE last birthday <u>88</u> yrs.		10. DATE OF BIRTH: <u>7-5-1866</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>WASHINGTON D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>ROBERT NELSON</u>		14. MOTHER'S MAIDEN NAME: <u>MARY</u>	
15. WAS DECEASED EVER IN U.S. ARMY OR NAVY (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Mrs. Ida Cole 310- Phila. Av. TAKOMA PARK MD.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
334X IMMEDIATE CAUSE (A) <u>TERMINAL HEART FAILURE</u>			
ANTECEDENT CAUSE (B) <u>BRONCHO PNEUMONIA</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>CEREBRA ARTERIOSCLEROSIS.</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan., 1955</u> to <u>July 13, 1955</u> , that I last saw the deceased alive on <u>July 11, 1955</u> , and that death occurred at <u>8:03 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Robert J. Philadelpo</u>		DATE SIGNED <u>7-13-55</u>	
ADDRESS <u>M.D. KENSINGTON, MD.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-16-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Smith Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-16-55</u>		REGISTRAR'S SIGNATURE <u>Francis E. [unclear]</u>	
24. FUNERAL DIRECTOR <u>J. W. [unclear]</u>		ADDRESS <u>Wash. D.C.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8 1/2 1000

Q180

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda Rural
 TOWN Bethesda Rural LENGTH OF STAY (in this place) 4 days
 HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Virginia COUNTY Fairfax
 CITY (If outside corporate limits, write RURAL and give nearest town) Rural
 TOWN Fairfax Rural
 STREET ADDRESS (If rural give location) Route III, Box 337A

3. NAME OF DECEASED:

(First) Donald Brian (Middle) COLLIER (Last) COLLIER

4. DATE (Month) (Day) (Year)
 OF DEATH: July 31 1955

5. SEX

Male

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH:

7-27-55

9. AGE last birthday 4 yrs.

IF UNDER 1 YEAR Months Days Hours Min.
4

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY: -----

11. BIRTHPLACE (State or foreign country): Bethesda Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME:

William Warren COLLIER

14. MOTHER'S MAIDEN NAME:

Mary Marjorie DRAKE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unk.) (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Father William Warren COLLIER Same as above

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

76.5
 IMMEDIATE CAUSE

(A)

CEREBRAL HEMORRHAGE

ANTECEDENT CAUSE (B)

DUE TO

PREMATURITY

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

INTERVAL BETWEEN ONSET AND DEATH

4 days

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 27 July, 1955 to 31 July, 1955 that I last saw the deceased alive on 31 July, 1955, and that death occurred at 9:55P M. from the causes and on the date stated above.

SIGNATURE George J. A. Magrant

ADDRESS

DATE SIGNED

G. J. MAGRANT LTJG USN U.S. Naval Hospital, NMC, Bethesda, Maryland

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial

8-4-55

Arlington National

Arlington, Virginia

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

8-1-55

Mary E. Ganelly

Ives Funeral Home

2817 Wilson Boulevard, Arlington, Virginia

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BURKHOFF V. S.

AUG 2 1953

11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68223
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
TOWN <i>Cherry Chase</i>		<i>20 A.</i>		TOWN <i>Wes.</i>		<i>4 x - 3</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Cherry Chase Country Club</i>				STREET ADDRESS (If rural, give location) <i>15 17</i>			
3. NAME OF DECEASED: (Type or Print)		(First) <i>Colbie</i>		(Middle) <i>Crump</i>		(Last)	
4. DATE OF DEATH		(Month) <i>July</i>		(Day) <i>14</i>		(Year) <i>1953</i>	
5. SEX: <i>male</i>		6. COLOR OR RACE: <i>col</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>SINGLE</i>		8. DATE OF BIRTH:	
9. AGE last birthday: <i>45</i> yrs.		10. UNDER 1 YEAR: Months Days		11. UNDER 24 HRS: Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>CADDY</i>				10b. KIND OF BUSINESS OR INDUSTRY: <i>GOLF CLUB</i>		11. BIRTHPLACE (State or foreign country): <i>NORWOOD, NORTH CAROLINA</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				13. FATHER'S NAME: <i>FRANK CRUMP</i>			
14. MOTHER'S MAIDEN NAME: <i>FANNIE PARKER</i>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			
16. SOCIAL SECURITY No.:				17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <i>Coronary occlusion</i>						<i>moderate</i>	
DUE TO						<i>diarr</i>	
Antecedent cause(s) (b)							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <i>Frank J. Broschart</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>7-14-53</i>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>7-15-53</i>		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <i>7-16-53</i>		REGISTRAR'S SIGNATURE <i>Beacie M. Thompson</i>		24. FUNERAL DIRECTOR <i>John T. China & Co.</i>		ADDRESS <i>901 - 32nd St.</i>	

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6824

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>2 hrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural give location) <u>10204 Oldfield Dr.</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) (Middle) (Last) <u>Thomas George Davies</u>				<u>July 10 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Married</u>		8. DATE OF BIRTH: <u>Mar 3, 1898</u>	
9. AGE last birthday: <u>57</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Wales</u>		11. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	
13. FATHER'S NAME: <u>George Davies</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Evans</u>			
15. WAS DECEASED EVER IN U.S. ARMY OR FOREST (Yes, no, or unk.) (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>188-12-82109M</u>		17. INFORMANT'S ADDRESS: <u>10204 Oldfield Dr. Kensington, Md.</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
163X IMMEDIATE CAUSE				(A) <u>Terminal Bronchopneumonia</u>			
ANTECEDENT CAUSE (S)				DUE TO <u>Carcinoma of the Right Lung</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>(26-8)</u>				(B) DUE TO			
				(C) <u>Myocardial Coronary Heart Disease</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>High blood pressure</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>28 Feb.</u> , 19 <u>55</u> , to <u>10 July</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10 July</u> , 19 <u>55</u> , and that death occurred at <u>6:10 P</u> M, from the causes and on the date stated above.				DATE SIGNED <u>10 July 1955</u>			
SIGNATURE <u>J. Blain Tibbalds</u>				ADDRESS <u>8218 Wisconsin Ave - Bethesda</u>			
M. D. <u>J. Blain Tibbalds</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/10/55</u>		<u>Washburn St. Cemetery</u>		<u>Exantom, Pa.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-11-55</u>		REGISTRAR'S SIGNATURE <u>Beason M. Thompson</u>		24. FUNERAL DIRECTOR <u>Warner E. Pumphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

30 8 108

100

6825

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>District of Columbia</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pethesda Rural</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington, D.C.</u> <u>41 X . E</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS <u>1046 Mahler Place, S.E.</u> <u>✓</u>			
3. NAME OF DECEASED:		(First) <u>John</u>		(Middle) <u>"D"</u>		(Last) <u>DI BENEDETTO</u>	
(Type or Print)						4. DATE (Month) (Day) (Year) OF DEATH: <u>July 30 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Cauc.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>27 July 1955</u>	9. AGE last birthday yrs <u>3</u>	IF UNDER 1 YEAR Months <u>3</u>	IF UNDER 24 HRS. Days <u>3</u>	Hours <u></u> Min. <u></u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>			10B. KIND OF BUSINESS OR INDUSTRY: -----	11. BIRTHPLACE (State or foreign country) <u>Bethesda, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Pietro DI BENEDETTO</u>				14. MOTHER'S MAIDEN NAME: <u>Juliette BOURNE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>None</u>				17. INFORMANT & ADDRESS: <u>Father Pietro DI BENEDETTO</u> <u>Same as above</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>760.5</u> <u>Intra-cranial hemorrhage</u>				<u>30 days</u>			
ANTECEDENT CAUSE (B) <u>Prematurity</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>27 July, 1955</u> to <u>30 July, 1955</u> , that I last saw the deceased alive on <u>30 July, 1955</u> , and that death occurred at <u>6:23 P M</u> , from the causes and on the date stated above.							
SIGNATURE <u>Howard A. Pearson</u>				ADDRESS		DATE SIGNED	
I. A. PEARSON LTJG MC USN U.S. Naval Hospital, NMC Bethesda, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial transit</u>		<u>8-3-55</u>		<u>St. Michael</u>		<u>Boston, Massachusetts</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>1-30-55</u>		<u>Mary E. Gandy</u>		<u>R. A. Pumbrey Funeral Home</u>		<u>7557 Wisconsin Avenue, Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STANDARD A. 1

106 2 1955

106 2 1955

CERTIFICATE OF DEATH

Reg. Dist. No.

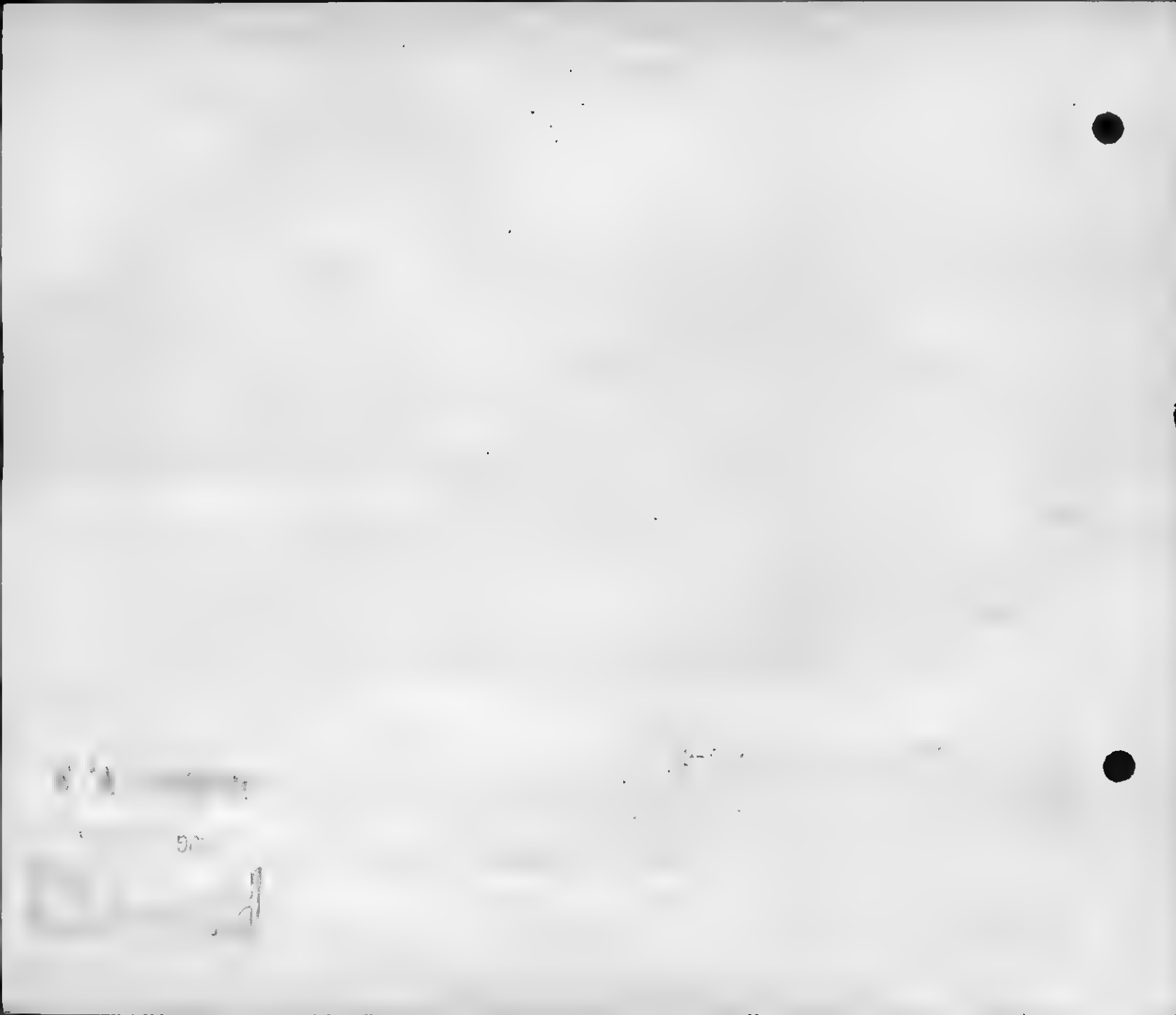
223

6773

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>Va.</i>		COUNTY <i>Prince William</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
17 TOWN <i>Takoma Park</i>		18 days		OR TOWN <i>Probesville</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Washington Sen & Hosp.</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED. (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED. <i>Mollie Elizabeth Diehl</i>				DATE OF DEATH <i>7 30 1955</i>			
5. SEX <i>Fe</i>		6. COLOR OR RACE <i>white</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>widow</i>		8. DATE OF BIRTH: <i>3-12-82</i>	
9. AGE last birthday <i>73</i> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>NSW</i>				10B. KIND OF BUSINESS OR INDUSTRY: <i>own home</i>			
11. BIRTHPLACE (State or foreign country): <i>Va.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME: <i>Samuel Hedrick</i>				14. MOTHER'S MAIDEN NAME: <i>Nancy Kerlin</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service: <i>-</i>				16. SOCIAL SECURITY NO. <i>-</i>			
17. INFORMANT'S ADDRESS: <i>Hospital Friends Takoma Park Ind.</i>							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
199. IMMEDIATE CAUSE (A) <i>Carcinoma of Stomach</i>							
ANTECEDENT CAUSE (B) <i>and/or Pancreas</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>17-19-55</i>				19B. MAJOR FINDINGS OF OPERATION: <i>Inoperable Carcinoma - Stomach - 1/4 Pancreas</i>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory OF INJURY street, office bldg. etc)			
21C. WHERE DID (City or town) (County) (State)				21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>7/12</i> , 19 <i>55</i> , to <i>7/30</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>7-30</i> , 19 <i>55</i> , and that death occurred at <i>7:30 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Arthur J. Farrell</i>				ADDRESS <i>M.D. 908 17th St. DC</i>			
DATE SIGNED <i>7-30-55</i>							
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				DATE THEREOF <i>8/2/55</i>			
NAME OF CEMETERY OR CREMATORY <i>Gallie View</i>				LOCATION (City, town, or county) <i>Probesville Va</i>			
DATE REC'D BY LOCAL REGISTRAR <i>July 30, 1955</i>				REGISTRAR'S SIGNATURE <i>J. E. ...</i>			
24. FUNERAL DIRECTOR <i>Hyattsville Ind.</i>				ADDRESS			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montg</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Montg</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>Bethesda</u>	<u>20.4</u>	TOWN <u>Bethesda</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp</u>		STREET ADDRESS (If rural, give location)	<u>5526 Dorsey Lane</u>
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>Emily Dorsey</u>		<u>7-18 1951</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u></u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u></u>	8. DATE OF BIRTH: <u>Apr. 1, 1869?</u>
9. AGE last birthday: <u>86</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u></u>		10b. KIND OF BUSINESS OR INDUSTRY: <u></u>	
11. BIRTHPLACE (State or foreign country): <u>Tiffany land</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Reuben West</u>		14. MOTHER'S MAIDEN NAME: <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u></u>	
17. INFORMANT & ADDRESS: <u>James Dorsey, 5526 Dorsey Lane (Son)</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
400.1 Immediate cause (a) <u>Coronary occlusion</u>		<u>Sudden</u>	
Antecedent cause(s) (b) <u>Generalized arteriosclerosis</u>			
Diseases or conditions, if any, giving rise to the above cause (c) <u></u>			
stating underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <u></u>		19b. MAJOR FINDING OF OPERATION: <u></u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Frank J. Brozchart</u>		M. D. ASSISTANT MEDICAL EXAM <u>7-18-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>7-21-55</u>	NAME OF CEMETERY OR CREMATORY: <u>Lincoln Park</u>	LOCATION (City, town, or county) (State): <u>Rockville Md.</u>
DATE REC'D BY LOCAL REG: <u>7-22-55</u>	REGISTRAR'S SIGNATURE: <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR: <u>Robert L. Snowden</u> ADDRESS: <u>Rockville Md.</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6827 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06804

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Kensington</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>	LENGTH OF STAY (in this place)	STREET ADDRESS (If rural give location) <u>3900 Saul Rd.</u>	
3. NAME OF DECEASED: (First) <u>Baby</u> (Middle) <u>Girl</u> (Last) <u>Ehrich</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July 24</u> 19 <u>55</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>July 23, 1955</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday IF UNDER 1 YEAR Months Days Hours Min. <u>14</u> <u>15</u>
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Louis Walter Ehrich</u>		14. MOTHER'S MAIDEN NAME: <u>Olivia May Whittington</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Father - 3900 Saul Rd.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Atelctasis</u>			<u>14 hrs.</u>
ANTECEDENT CAUSE (B) <u>Failure of lung expansion</u>			<u>14 hrs.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Prematurity (28 weeks)</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>7/23/55</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTR BUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7/23, 1955</u> , to <u>7/24, 1955</u> , that I last saw the deceased alive on <u>7/24, 1955</u> , and that death occurred at <u>10:00</u> AM, from the causes and on the date stated above.			
SIGNATURE <u>Michael J. Buckley</u> M.D.		ADDRESS <u>4630 Montgomery Ave. Bethesda</u> DATE SIGNED <u>7/24/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-27-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/28/55</u>		REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u>	
4. FUNERAL DIRECTOR <u>Robert R. Humphrey</u>		ADDRESS <u>Bethesda Md.</u>	

BUREAU V. S.

AUG 1 1951

RECEIVED

6828

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>MONTGOMERY</u> MARYLAND <u>MD</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> TOWN <u>BETHESDA</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RESMORE SANITARIUM BETHESDA, MD.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>MONTGOMERY</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BETHESDA</u> STREET ADDRESS (If rural give location) <u>5623 HUNTINGTON PARKWAY</u>	
3. NAME OF DECEASED: (Type or Print) <u>WILLIAM FENTRESS ELLIOTT</u> (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <u>JULY 25</u> 19 <u>55</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>	8. DATE OF BIRTH: <u>18 July 1873</u>
9. AGE last birthday: <u>82</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>MORTICIAN</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>JOHN WESLEY ELLIOTT</u>		14. MOTHER'S MAIDEN NAME: <u>MARIA WOODEND</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>LEONARD I. BARRETT Bethesda, Md.</u>	

18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>331X</u> IMMEDIATE CAUSE (A) <u>Uremia</u> ANTECEDENT CAUSE (B) <u>Due to</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Due to</u>		INTERVAL BETWEEN ONSET AND DEATH <u>approx one month</u>
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II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Cerebral Vascular Accident on 14 May 1955 resulting in mild paresis of both</u>	
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19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION: <u>Left extremities</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 23 July, 1955, to 25 July, 1955, that I last saw the deceased alive on 25 July, 1955, and that death occurred at 6:35 A.M., from the causes and on the date stated above.

SIGNATURE <u>Jack W. Sanders</u>	ADDRESS <u>M.D. Calvin Johns Md</u>	DATE SIGNED <u>25 July 55</u>
23. BURIAL CREMATION, REMOVAL (SPECIFY) <u>Removal Burial</u>	DATE THEREOF <u>7-25-55</u>	NAME OF CEMETERY OR CREMATORY <u>Washington, D.C.</u>
DATE REC'D BY LOCAL REGISTRAR <u>7-28/55</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>W. W. Chambers Co</u> ADDRESS <u>1400 Chapin St NW Wash D.C.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully! The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U.S. DEPARTMENT OF AGRICULTURE

AUG 1 1909

W. A. R. 1909

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>4 days</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Poolesville</u>		TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>				STREET ADDRESS (If rural, give location) <u>Rural</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Charles Thomas Ernst</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>7-17-1953</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>6-17-53</u>	
9. AGE last birthday: <u>2</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		11. BIRTHPLACE (State or foreign country): <u>Mont. Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>George Milton Ernst</u>				14. MOTHER'S MAIDEN NAME: <u>Erma Hagenbaugh</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Norman Smith - Box 28, Beallville</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Shock</u>						<u>9 days</u>	
DUE TO							
Antecedent cause(s) (b) <u>1st and 2nd degree burns resulting from about 3/4 of today's sunburn</u>							
DUE TO							
stating underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>		21c. (City or town) (County) (State) <u>Poolesville Montg Md</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7-8 5:13 PM.</u>				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Playing with matches at home</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broachant</u>				M. D. ASSISTANT MEDICAL EXAM. <u>7-17-53</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>7-20-53</u>		NAME OF CEMETERY OR CREMATORY <u>Wood Oak</u>		LOCATION (City, town, or county) (State) <u>Farmington Md.</u>	
DATE REC'D BY LOCAL REG. <u>Aug 20 53</u>		REGISTRAR'S SIGNATURE <u>Beauregard M. Thompson</u>		24. FUNERAL DIRECTOR <u>Scott C. Yorkman Farmington Md.</u>			



6830

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND				STATE <u>District of Columbia</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pethesda</u> RURAL				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>			
TOWN <u>Pethesda</u> RURAL				TOWN <u>Washington, D.C.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>1331 Ives Place S.E.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Martin</u> (N) <u>EURKOOS</u>				<u>July</u> <u>25</u> <u>1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>9-10-79</u>	
9. AGE last birthday <u>75</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Musician</u>		11. BIRTHPLACE (State or foreign country): <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Vincent EURKOOS</u>				14. MOTHER'S MAIDEN NAME: <u>Veronica DOUNIS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT & ADDRESS: <u>Wife Louise C. EURKOOS</u>				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. DATE OF OPERATION: <u>7-29-55</u>			
IMMEDIATE CAUSE (A) <u>myocardial infarction</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
ANTECEDENT CAUSE (S) <u>CORONARY OCCLUSION</u>				21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (B) <u>CORONARY ATHEROSCLEROSIS</u>				22. I hereby certify that I attended the deceased from <u>24 July, 1955</u> , to <u>25 July, 1955</u> , that I last saw the deceased alive on <u>24 July, 1955</u> , and that death occurred at <u>3:30 A.M.</u> , from the causes and on the date stated above.			
(C) <u>CORONARY ATHEROSCLEROSIS</u>				23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> DATE THEREOF <u>7-29-55</u> NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> LOCATION (City, town, or county) <u>Arlington, Virginia</u>			
19A. DATE OF OPERATION: <u>7-29-55</u>				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?				21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			
21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>24 July, 1955</u> , to <u>25 July, 1955</u> , that I last saw the deceased alive on <u>24 July, 1955</u> , and that death occurred at <u>3:30 A.M.</u> , from the causes and on the date stated above.				23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> DATE THEREOF <u>7-29-55</u> NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> LOCATION (City, town, or county) <u>Arlington, Virginia</u>			
24. FUNERAL DIRECTOR: <u>Chambers Funeral Home</u>				25. DATE REC'D BY LOCAL REGISTRAR: <u>7-25-55</u> REGISTRAR'S SIGNATURE: <u>Mary E. Connelly</u>			
26. ADDRESS: <u>517 11th Street, S.E., Washington, D.C.</u>				27. DATE SIGNED: <u>7-25-55</u>			

MARGIN RESERVED FOR BINDING

VS. A15 -- 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U.S. AIR FORCE

1955

6831

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>MONTGOMERY</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>MONTGOMERY</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>KENSINGTON</u>		<u>6/14/55-7/3/55</u>		OR TOWN <u>SILVER SPRING</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)					
<u>KENSINGTON GARDENS NURSING HOME</u>		<u>704 Hankin St.</u>					
3000 McComas Ave.							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Sophie Fisher</u>				<u>7-3-1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday: IF UNDER 1 YEAR, Months Days	IF UNDER 24 HRS, Hours Min.		
<u>F</u>	<u>W.</u>	<u>SINGLE</u>	<u>Sept 16 1872</u>	<u>82</u> yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>none</u>				<u>St Louis Mo.</u>		<u>U.S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Henry Fisher</u>				<u>Regina</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
				<u>Mrs. Anna Vierling, 704 Hankin St. Silver Spring, Md.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
332X IMMEDIATE CAUSE						<u>3 days</u>	
(A) DUE TO <u>Cerebral Thrombosis</u>							
ANTECEDENT CAUSE (B)						<u>5 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						<u>5 yrs</u>	
(B) DUE TO <u>Cerebral arteriosclerosis</u>							
(C) DUE TO <u>Generalized arteriosclerosis</u>						<u>15 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>2 days</u>	
<u>Pulmonary edema</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>None</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>(over)</u>			
22. I hereby certify that I attended the deceased from <u>2 July, 1955</u> , to <u>3 July, 1955</u> , that I last saw the deceased alive on <u>2 July, 1955</u> , and that death occurred at <u>1:45 P.M.</u> M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Maria J. White</u>		<u>60 Ave H St</u>		<u>July 55</u>			
M.D. <u>11/14</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/5/55</u>		<u>Ft. Lincoln Cemetery</u>		<u>Prince George County, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7-5-55</u>		<u>Frances Potter</u>		<u>Wannin & Humphrey</u>		<u>8434 Ga. Ave. Silver Spring, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3 July 55.

I saw this patient for D. M. Cross
who was on vacation the 2+3 July 55.
Her history shows a gradual downhill
course since admission to Kensington
Audens - more rapid deterioration beginning
30 June 55.

M. J. White M.D.

U.S. A. 1000000

1955 3 7

DEPT. OF HEALTH

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06809

6832

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		STATE <u>Virginia</u>		COUNTY <u>Tauifos</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 4 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria 83x-3</u>		OR TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural give location) <u>18-E. Monroe Ave. ✓</u>					
3. NAME OF DECEASED: (First) <u>Battie</u> (Middle) <u>Justis</u> (Last) <u>Fleming</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>July 8 1955</u>			
5. SEX. <u>Female</u>	6. COLOR OR RACE. <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>June 18 1877</u>	9. AGE last birthday <u>78</u> yrs	IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>-</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>	
13. FATHER'S NAME: <u>William M. Justis</u>				14. MOTHER'S MAIDEN NAME: <u>Hevianna Sanford</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT'S ADDRESS: <u>Phyllis Lee Suburban Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>600.0</u>		DUE TO <u>Uremia</u>				<u>4 days</u>	
ANTECEDENT CAUSE (B) <u>Chronic pyelonephritis</u>		DUE TO				<u>3 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>arteriosclerosis, general lipoh. Hypertensive cardiovascular disease</u>		DUE TO				<u>15 years</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>15 years</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/5, 1955</u> , to <u>7/8, 1955</u> , that I last saw the deceased <u>July 7, 1955</u> , and that death occurred at <u>3:01 AM</u> , from the causes and on the date stated above.							
alive on SIGNATURE <u>Robert H. Boale</u>		M. D.		DATE SIGNED <u>July 8, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Funeral</u>		DATE THEREOF <u>July 8, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Alexandria Va.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>7/9/55</u>		REGISTRAR'S SIGNATURE <u>Beattie M. Thompson</u>		FUNERAL DIRECTOR <u>W. N. Demaine</u>		ADDRESS <u>520 S. Washington St. Alex. Va.</u>	



RECEIVED
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JOINT CHIEFS OF STAFF
WASHINGTON, D.C.

6832

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06810

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Silver Spring</u>	<u>3 years</u>	OR TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1604 South Springwood Drive</u>		STREET ADDRESS (If rural give location)	<u>1604 South Springwood Drive</u>
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Charles W. Forni</u>		OF DEATH: <u>July 15 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Aug. 11, 1909</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Engineer - Wash. Sub. Sanitary Comm.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Fairview, Ohio</u>	11. BIRTHPLACE (State or foreign country): <u>U. S. A.</u>
13. FATHER'S NAME: <u>George W. Forni</u>		14. MOTHER'S MAIDEN NAME: <u>Mollie Workman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO: <u>214-03-8695</u>	
17. INFORMANT & ADDRESS: <u>Mary H. Forni, 1604 So. Springwood Drive, SS</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cardiac failure</u>		<u>10 min</u>	
ANTECEDENT CAUSE (S) (B) <u>Coronary thrombosis & infarction</u>		<u>36 hrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Generalized arteriosclerotic dise.</u>		<u>—</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Mar</u> , 1955, to <u>July</u> , 1955 that I last saw the deceased <u>live on</u> <u>15 July 1955</u> and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Ernest E. Harmon</u>		ADDRESS <u>9301 Colesville Rd. Silver Spring, Md. 20910</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/18/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-18-55</u>		REGISTRAR'S SIGNATURE <u>Rance T. Warner</u>	
24. FUNERAL DIRECTOR <u>Warner & Humphrey</u>		ADDRESS <u>8434 George A. Ave. Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

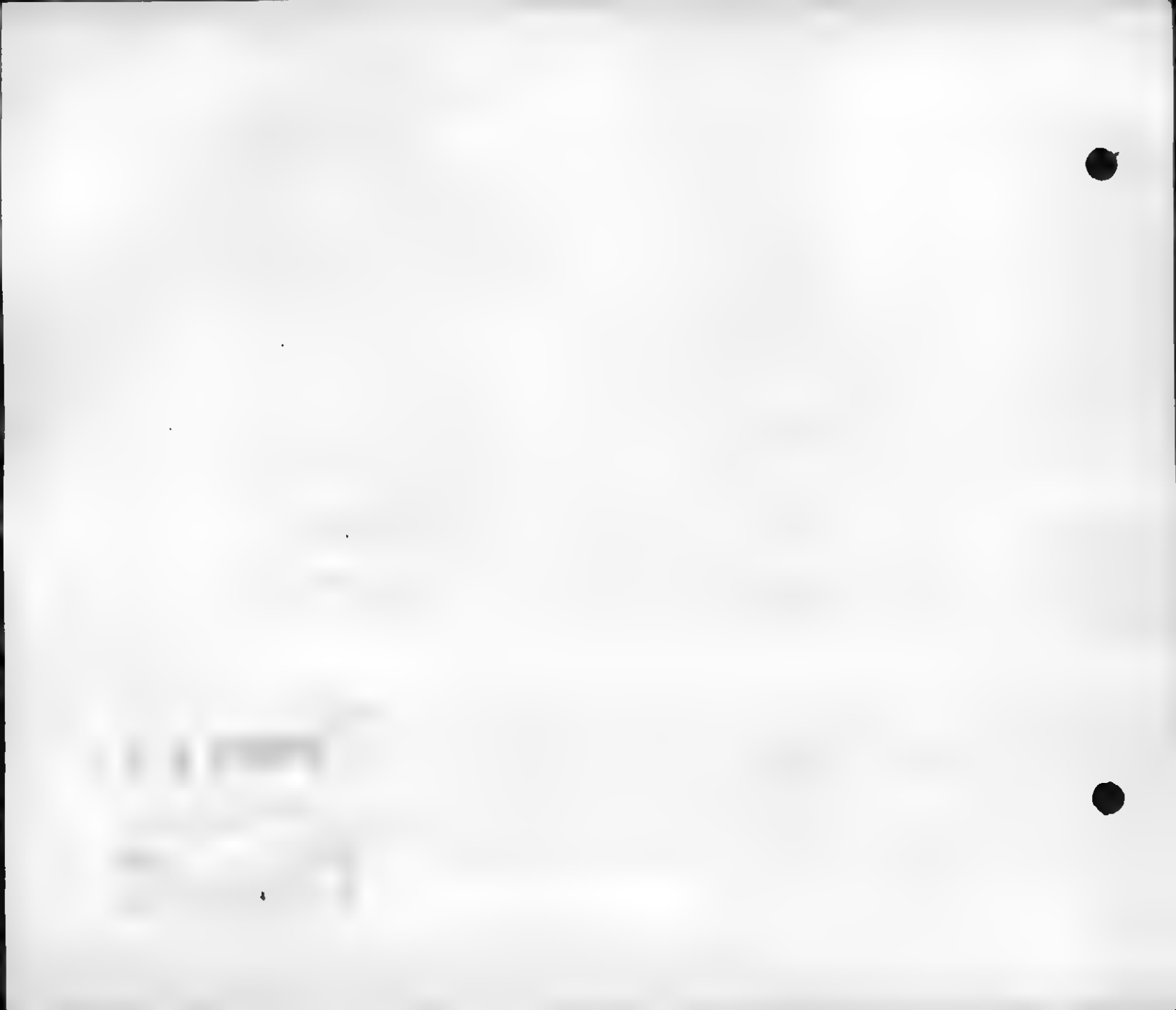


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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 76811
 6834 Items 1,7, 4 7-10-55
CERTIFICATE OF DEATH Reg. Dist. No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		X	
X TOWN <u>Kensington, Md.</u>				STREET ADDRESS (If rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Carroll Hall Saut.</u>				H007 Presler			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH: (Month) (Day) (Year)			
First (Middle) (Last) <u>DONALD FRASER</u>				July 8 1955			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH: <u>Oct 15 1867</u>	
9. AGE last birthday, if under 1 year		10. AGE last birthday, if under 24 yrs.		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY:	
67 yrs.		67 yrs.		Saut.		Scotland	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clergy</u>				10B. KIND OF BUSINESS OR INDUSTRY:			
13. FATHER'S NAME: <u>John A.C. FRASER</u>				14. MOTHER'S MAIDEN NAME: <u>Jennie Hallar</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT & ADDRESS: <u>Mrs J.A. Nolan Daughter</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>ACUTE MYOCARDITIS</u>							
ANTECEDENT CAUSE (B) <u>CHRONIC MYOCARDITIS</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>GENERALIZED ARTERIOSCLEROSIS</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>SENILITY</u>							
19A. DATE OF OPERATION: <u>NONE</u>				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, street, office bldg., etc.)			
				21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While [] Not while [] at work [] at work []			
				21F. HOW DID INJURY OCCUR? <u>NONE</u>			
22. I hereby certify that I attended the deceased from <u>JAN. 9, 1955</u> , to <u>July 8, 1955</u> , that I last saw the deceased alive on <u>July 8, 1955</u> , and that death occurred at <u>1 P M</u> , from the causes and on the date stated above.							
SIGNATURE <u>Henry Lowden</u>				ADDRESS <u>5206 NORWAY DR. Chevy Chase, Md.</u> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)			
<u>Burial</u>				<u>Wells River Cem. Wells River Vt.</u>			
DATE REC'D BY LOCAL REGISTRAR <u>7-8-55</u>				24. FUNERAL DIRECTOR ADDRESS <u>Local Funeral Home 4812 9th NW Wash</u>			
REGISTRAR'S SIGNATURE <u>Frances Potter</u>							



6835

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Kensington</u>				OR TOWN <u>Kensington</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Le Deau Gardens Rest Home</u>				STREET ADDRESS (If rural give location) <u>4221 Everett St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Lewis G. FRAZIER</u>				<u>July 3, 1955</u>			
5. SEX.	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>3-28-1864</u>	<u>91</u> yrs	<u>3</u> Months	<u>5</u> Days	<u>19</u> Mins.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Doctor Med. Ret. Medicine</u>						<u>Oxford, No. Carolina</u>	
13. FATHER'S NAME:				12. CITIZEN OF WHAT COUNTRY?			
<u>Unknown</u>				<u>U.S.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):				15. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS.	
<u>Bi</u>				<u>No</u>		<u>Karl B. Frazier</u> <u>Son, 4221 Everett St. Kensington, Md.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>471X</u> <u>Branchopneumonia, bilateral</u> <u>2 days</u>							
ANTECEDENT CAUSE (B) <u>Generalised arteriosclerosis, advanced</u> <u>10 yrs</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>0</u>							
20. AUTOPSY?							
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY—street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1953</u> , to <u>July 3, 1955</u> , that I last saw the deceased alive on <u>July 3, 1955</u> , and that death occurred at <u>5:28 PM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Stewart Mapp</u>		<u>3921 Ingomar St. N.W.</u>		<u>July 3, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-6-55</u>		<u>Kingston Cem.</u>		<u>Somerset Co. New Jersey</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7/4/55</u>		<u>Bessie M. Thompson</u>		<u>Robert A. Humphrey</u>		<u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINNING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

RECEIVED

JUL 9 1964

10

6836

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:

COUNTY **Montg.** MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) **Gaithersburg Rural** LENGTH OF STAY **77 yrs**
 OR (in this place)
 TOWN
 HOSPITAL OR
 INSTITUTION OR
 STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland** COUNTY **Montg**
 CITY (If outside corporate limits, write RURAL and give nearest town) **Gaithersburg**
 OR
 TOWN
 STREET ADDRESS **Rural** (If rural give location)

3. NAME OF DECEASED:

(First) **Martha** (Middle) **Jane** (Last) **Frazier**

4. DATE OF DEATH: (Month) **July** (Day) **7** (Year) **1955**

5. SEX:
Female

6. COLOR OR RACE:
Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) **Widow**

8. DATE OF BIRTH:
Apr 3-1878

9. AGE last birthday: **77** yrs. IF UNDER 1 YEAR: Months **3** Days **4** IF UNDER 24 HRS. Hours **1** Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: **house wife**

10b. KIND OF BUSINESS OR INDUSTRY: **Home Work**

11. BIRTHPLACE (State or foreign country): **Gaithersburg, Rural Md.**

12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME:

John H. Chase

14. MOTHER'S MAIDEN NAME:

Matilda Chase

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) **9** (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Rosa L. Snowden. Gaithersburg Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X
 Immediate cause

(a) **Cerebral Hemorrhage**

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) **Hypertension**

DUE TO

(c)

Interval Between Onset And Death

2 days

8 yrs

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **June 1954**, to **July 7, 1955**, that I last saw the deceased alive on **July 6, 1955**, and that death occurred at **6:00pm**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF **7-11-55**

NAME OF CEMETERY OR CREMATORY **Brook Grove**

LOCATION (City, town, or county) (State) **Laytonsville. Md.**

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

July 10, 1955

Amelia G. Cook

Ernest C. Gartner, Gaithersburg Md.

MARGIN RESERVED FOR BINDING

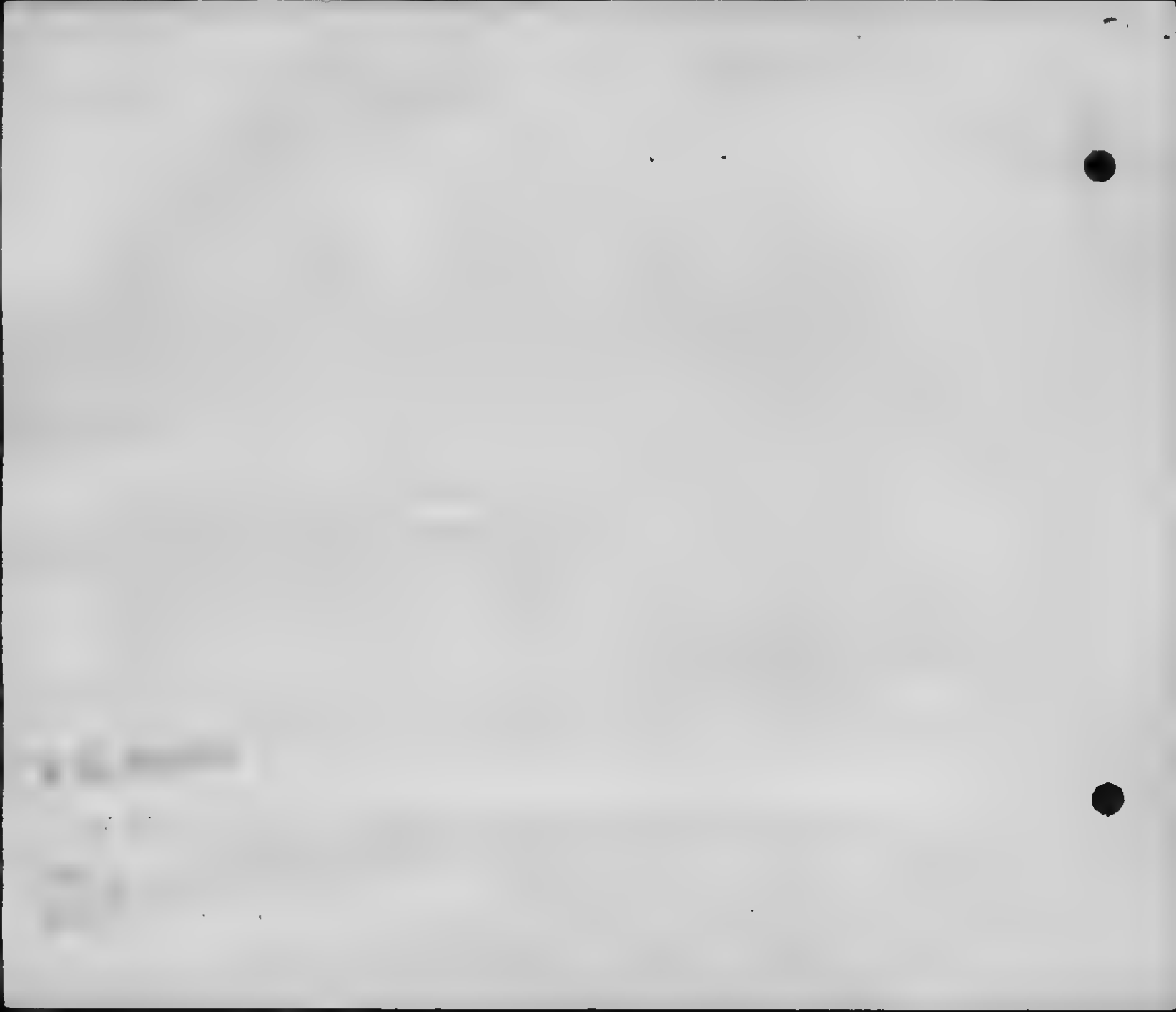
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED
JUL 1 1964

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6937				06814			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Bethesda</u>		<u>4 yrs.</u>		TOWN <u>Bethesda</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
<u>4505 N Chelsea st</u>				<u>4505 N. Chelsea st</u>			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
<u>Goldie Montana</u>		<u>Frisby</u>		<u>July 19</u>		<u>1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>1-12-1903</u>	<u>52</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>Mont.</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John W. Huffman</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
				<u>Roy E. Frisby (husband) Same as item 2</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>971.2</u> Immediate cause (a)..... <u>Carbolic acid poisoning (suicide)</u> DUE TO Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c).....							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED	
<u>Frank J. Broschart</u>						<u>7</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Cremation</u>		<u>7-23-55</u>		<u>Cedar Hill</u>		<u>Suitland, Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7-20-55</u>		<u>Wesley W. Thompson</u>		<u>Robert A. Humphrey</u>		<u>Bethesda, Md.</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

68339

CERTIFICATE OF DEATH

Reg. Dist. No. 216

06815

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		STATE <u>md.</u> COUNTY <u>Montgomery</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		TOWN <u>Cherry Chase</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>31 days 6 hrs.</u>		STREET ADDRESS (If rural give location) <u>7208 Oakridge Ave.</u>		ADDRESS <u>Cherry Chase</u>	
3. NAME OF DECEASED: (First) <u>John</u> (Middle) <u>Lea</u> (Last) <u>Fuller</u>				4. DATE (Month) <u>7</u> (Day) <u>5</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>1-8-37</u>	
9. AGE last birthday <u>6</u> yrs. <u>5</u> Months <u>27</u> Days <u></u> Hours <u></u> Min.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Tipton, Iowa</u>	
13. FATHER'S NAME: <u>John Henderson</u>				14. MOTHER'S MAIDEN NAME: <u>Minnie</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u></u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT'S ADDRESS: <u>Stephen Hill - Husband</u> <u>7208 Oakridge Ave. Cherry Chase</u>				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>Cerebrovascular Accident</u>				<u>6/5-1/5/55</u>			
ANTECEDENT CAUSE (B) <u>Cerebral arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Myocardial infarction</u> <u>Chronic congestive heart failure</u>							
19A. DATE OF OPERATION: <u></u>				19B. MAJOR FINDINGS OF OPERATION: <u></u>			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>6-5-55</u> , to <u>7-5-55</u> , that I last saw the deceased alive on <u>7-5-55</u> , 19 <u>55</u> , and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>George A. Gray, Jr.</u>				M. D. <u>Cherry Chase</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-8-55</u>		<u>Pt. Lincoln</u>		<u>Prince George Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/6/55</u>		REGISTRAR'S SIGNATURE <u>Jessie M. Hinton</u>		24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

EDWARD V. S.

CHAS. H. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

6771

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> OR <u>21 days</u> TOWN <u>Washington San. & Hosp.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>75</u>		STATE <u>Maryland</u> COUNTY <u>Prince Georges</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>16-16-2</u> OR <u>3370 Chillum Rd</u> TOWN <u>APT. No. V</u> STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
DECEASED: (Type or Print) <u>Frank Biers Gallagher</u> OF DEATH: <u>7-3-1955</u>		DATE OF DEATH: <u>7-3-1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>12-9-88</u>
9. AGE last birthday		10. BIRTHPLACE (State or foreign country):	
<u>66 yrs</u>		<u>Minnesota</u>	
11. CITIZEN OF WHAT COUNTRY?		12. CITIZEN OF WHAT COUNTRY?	
<u>Amer - USA</u>		<u>Amer - USA</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Michael Gallagher</u>		<u>Jane Murray</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO	
<u>Yes</u> <u>WWI Army</u>		<u>None</u>	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
<u>Hospital Records</u> <u>Washington Sanitarium & Hospital</u>		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>4521</u> IMMEDIATE CAUSE (A) <u>Congestive Cardiac Failure</u> ANTECEDENT CAUSE (B) <u>Diabetic Gangrene</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Arteriosclerosis</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>6/13/1955</u> , to <u>7/3/1955</u> , that I last saw the deceased alive on <u>7/3/1955</u> , and that death occurred at <u>9:20 PM</u> , from the causes and on the date stated above.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. FUNERAL DIRECTOR	
DATE THEREOF <u>7/6/1955</u> NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem.</u> LOCATION (City, town, or county) <u>Colmar Manor, Pa. Colo. Md.</u> (State)		ADDRESS <u>7/4/55</u> DATE REC'D BY LOCAL REGISTRAR <u>July-5-1955</u> REGISTRAR'S SIGNATURE <u>J. Wilson Dodd</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2000000000

1000000000

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CERTIFICATE OF DEATH

Reg. Dist. No. 216

6832

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Ethesda</u>	LENGTH OF STAY (in this place) <u>6 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring 56</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>74 Suburban</u>		STREET ADDRESS (If rural give location) <u>12220 Bluehill Rd.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) (Middle) (Last) <u>Francisco Juarda Galope</u>		(Month) (Day) (Year) <u>July 13 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Jan. 17, 1885</u>
9. AGE last birthday: <u>70</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Chef</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Manila, P. I.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>unknown</u>		14. MOTHER'S MAIDEN NAME: <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS: <u>Wife, Virginia Galope - above</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>			<u>6 Days</u>
ANTECEDENT CAUSE (B) <u>Cerebral atherosclerosis.</u>			<u>5 years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) <u>Hypertension, arterial.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 7, 1955</u> , to <u>July 13, 1955</u> that I last saw the deceased alive on <u>July 13, 1955</u> , and that death occurred at <u>4:35 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>James A. Roberts</u>		ADDRESS <u>8907 Georgia Ave. Silver Spring, Md</u> DATE SIGNED <u>July 13, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>REMOVED</u>		DATE THEREOF <u>JULY 13 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Glennwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>July 16 1955</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
24. FUNERAL DIRECTOR <u>W. K. Hunt</u>		ADDRESS <u>5532 Georgia Ave Washington D.C.</u>	

MARGIN RESERVED FOR INDEXING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



7 5 771010

JUL 1

11

CERTIFICATE OF DEATH

Reg. Dist. No. 215

6842

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Prince Georges</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<input checked="" type="checkbox"/> TOWN <u>Bethesda</u> <u>Rural</u>	<u>1 Hr 20 min</u>	OR TOWN <u>Suitland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>		STREET ADDRESS (If rural give location) <u>4775 Huron Avenue</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Michael</u>	(Middle) <u>Paul</u>	(Last) <u>Galutzi</u>	(Month) <u>July</u> (Day) <u>3</u> (Year) <u>19 55</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>11-1-09</u>
9. AGE last birthday <u>45</u> yrs		10. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME: <u>Joseph GALLUZO</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service) <u>Yes</u> <u>VW II</u>		16. SOCIAL SECURITY NO. <u>578 44 1973</u>	
17. INFORMANT & ADDRESS: <u>Wife Alwilda E. GALUTZI</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>		<u>1 hour</u>	
ANTECEDENT CAUSE (B) <u>Coronary Atherosclerosis</u>		<u>1 year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTR. BUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>7-3-55</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3 July, 1955</u> , to <u>3 July, 1955</u> , that I last saw the deceased <u>alive on 3 July 1955</u> , and that death occurred at <u>9:00PM</u> , from the causes and on the date stated above.			
SIGNED <u>Dr. J. H. Jones</u>		ADDRESS <u>U. S. Naval Hospital, NMHC, Bethesda, Maryland</u>	
DATE SIGNED <u>7-7-55</u>			
BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-3-55</u>		LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
REGISTRAR'S SIGNATURE <u>Dr. J. H. Jones</u>		24. FUNERAL DIRECTOR ADDRESS <u>Simmons Bros. 1661 Goodhope Road, S.E. Annapostia, D.C.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ST. PAUL, MINN.

1891

10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 214

I. PLACE OF DEATH:

COUNTY MONTGOMERY MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) SILVER SPRING
 TOWN SILVER SPRING
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 827 PHILADELPHIA AVE.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD. COUNTY MONTGOMERY
 CITY (If outside corporate limits write RURAL and give nearest town) SILVER SPRING
 TOWN SILVER SPRING
 STREET ADDRESS (If rural, give location) 827 PHILADELPHIA AVE.

3. NAME OF DECEASED:

(First) ROBERT (Middle) EDWARD (Last) GARDNER
 (Type or Print)

4. DATE OF DEATH

(Month) JULY (Day) 31 (Year) 1955

5. SEX:

M

6. COLOR OR RACE:

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

MARRIED

8. DATE OF BIRTH:

JUNE 19, 1908

9. AGE last birthday:

47 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

MALE NURSE

10b. KIND OF BUSINESS OR INDUSTRY:

GENERAL DUTY NURSING

11. BIRTHPLACE (State or foreign country):

SUNDERLAND, ENGLAND

12. CITIZEN OF WHAT COUNTRY?

USA.

13. FATHER'S NAME:

ROBERT GARDNER

14. MOTHER'S MAIDEN NAME:

ELIZABETH HARTY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

NO

16. SOCIAL SECURITY No.:

NO

578-03-5514

17. INFORMANT & ADDRESS:

EDITH D. GARDNER 827 PHILADELPHIA AVE., SILVER SPRING, MD.

II. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1

Immediate cause

(a).....

DUE TO

Coronary occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b).....

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

Sudden

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Francis J. Broschart

M. D.

CHIEF MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

ASSISTANT MEDICAL EXAM.

DATE SIGNED

7-4-55

23. BURIAL, CREMATION, REMOVAL (Specify):

BURIAL

DATE THEREOF

July 6, 1955

NAME OF CEMETERY OR CREMATORY

GEORGE WASHINGTON CEMETERY

LOCATION (City, town, or county)

Riggs Rd., Hyattsville, Prince Georges Co., Md.

(State)

DATE REC'D BY LOCAL REG.

7-5-55

REGISTRAR'S SIGNATURE

Francis J. Broschart

24. FUNERAL DIRECTOR

254 CARROLL ST. N.W.,

ADDRESS

TAKOMA PARK 12, D.C.



1-1-1955

10-1-1955

6775

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Takoma Park</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium and Hospital</u>	MARYLAND LENGTH OF STAY (in this place) <u>22 days</u>	STATE <u>Dist. of Cal.</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington</u> STREET ADDRESS (If rural give location) <u>47X-3</u> <u>6416 31st St. N.W.</u>	
3. NAME OF DECEASED: (Type or Print) <u>Mary Elizabeth Garland</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>7</u> <u>2</u> <u>1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Cauc.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>11-1-79</u>
9. AGE last birthday: <u>75</u> yrs		10. BIRTHPLACE (State or foreign country): <u>D.C.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Hswf</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>William Bowles</u>		14. MOTHER'S MAIDEN NAME: <u>Melinda Mattingly</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>(If Yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Hospital Record</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>155X</u> ANTECEDENT CAUSE (B) <u>Primary carcinoma-liver</u>		?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.		(B) DUE TO	
(C)		(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerotic heart disease</u>			
19A. DATE OF OPERATION.		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-6</u> , 19 <u>55</u> , to <u>7-2</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/2</u> , 19 <u>55</u> , and that death occurred at <u>540P</u> M. from the causes and on the date stated above.			
SIGNATURE <u>Francis R. [illegible]</u>		DATE SIGNED <u>7/1/55</u>	
M.D. <u>7712 Alaska Ave N.W. Wash. D.C.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
DATE THEREOF <u>7-6-55</u>		<u>Mt. Olivet, Gen</u>	
LOCATION (City, town, or county) (State) <u>Washington DC</u>			
DATE REC'D BY LOCAL REGISTRAR <u>7-5-55</u>		REGISTRAR'S SIGNATURE <u>Francis [illegible]</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>4401-14th St. N.W.</u>	

MARGIN RESERVED FOR BINDING

8 1057

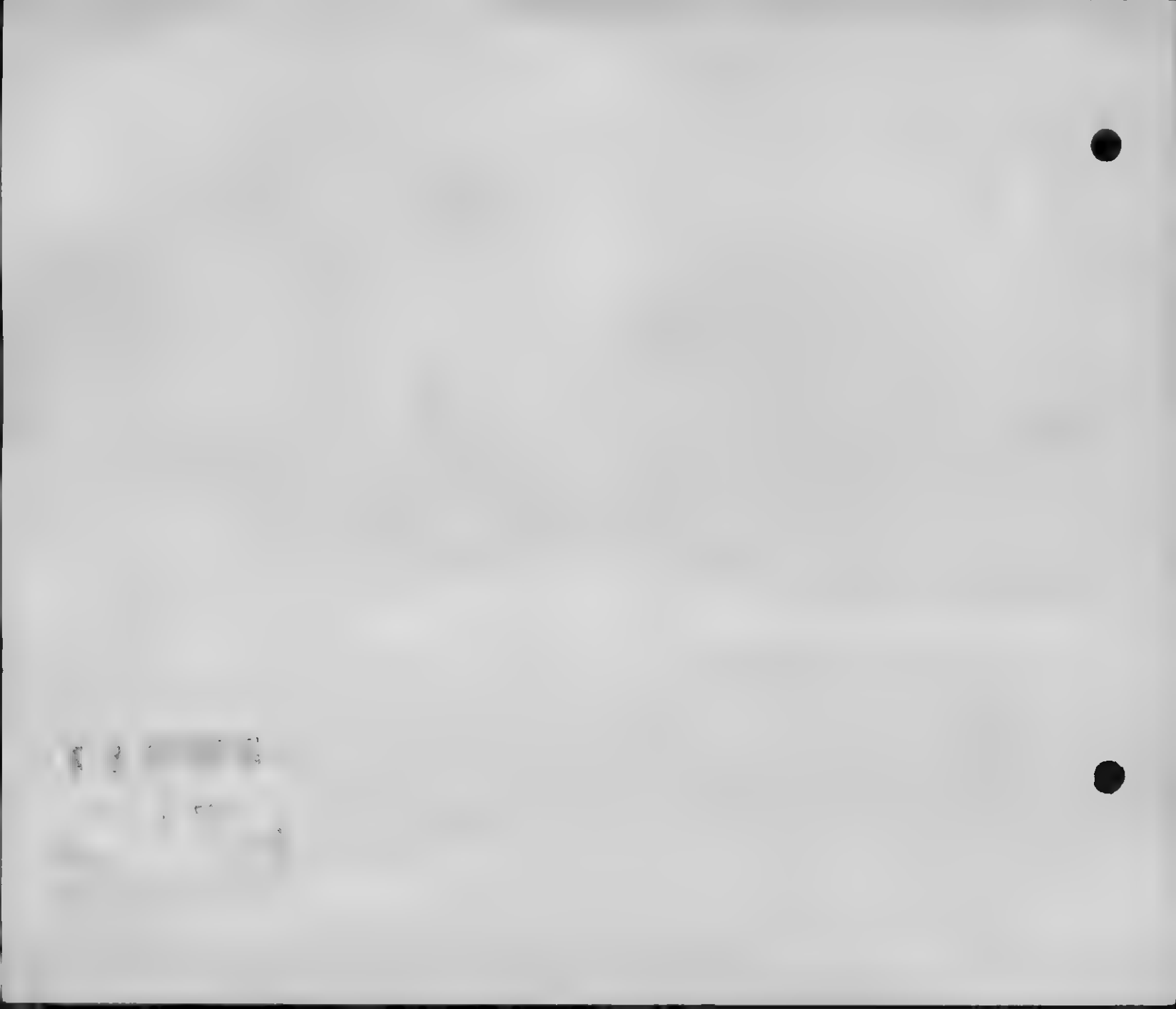
8 1057

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9842
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06821
Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Montgomery</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
<i>X</i> TOWN <i>Bethesda</i>		<i>D.C.</i>		TOWN <i>Silver Spring</i>		<i>MD</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
<i>74 Suburban</i>				<i>2612 Spencer Road</i>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First)		(Middle)		(Last)		(Month) (Day) (Year)	
<i>Ben</i>		<i>Hill</i>		<i>Marriett</i>		<i>July 31 1955</i>	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
<i>Male</i>		<i>White</i>		<i>Married</i>		<i>April 27, 1886</i>	
9. AGE last birthday:		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>64 yrs.</i>		<i>Own business grocery</i>		<i>South Carolina</i>		<i>U.S.</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Marriett</i>				<i>Lyness, David</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:			
				<i>160-111111-1111</i>			
17. INFORMANT & ADDRESS:				18. MEDICAL CERTIFICATION			
<i>Mrs. Evelyn L. Marriett</i>				<i>160-111111-1111, Silver Spring, Md.</i>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET OF DEATH			
<i>900.0</i>				<i>Immediate</i>			
Immediate cause				<i>(a) Extensive cerebral contusions</i>			
Antecedent cause(s)				<i>(b) Extensive fracture of Basal skull</i>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last				<i>(c) Fall down stairs</i>			
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY?							
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY)		21c. (City or town) (County) (State)			
		<i>Home</i>		<i>Silver Spring Monty MD</i>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<i>7-31-55 8:30 P.M.</i>				<i>Fell down basement stairs</i>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE				CHIEF MEDICAL EXAMINER			
<i>Frank J. Broschart</i>				<input checked="" type="checkbox"/> DATE SIGNED			
				DEPUTY MEDICAL EXAMINER			
				<input checked="" type="checkbox"/> 8-1-55			
23. BURIAL, CREMATION, REMOVAL (Specify)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<i>Tr. to St. Peter's</i>		<i>8/2/55</i>		<i>Memorial Park Cemetery</i>		LOCATION (City, town, or county) (State)	
						<i>St. Petersburg, Florida</i>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>8/2/55</i>		<i>Bessie M. Thompson</i>		<i>Warner & Humphrey</i>		<i>8434 Ga. Ave. Silver Spring, Md.</i>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06822			
tem 18 Film G184 8-5-55 ans			
6776 CERTIFICATE OF DEATH			
Reg. Dist. No. 223			
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Montgomery</u> MARYLAND <input checked="" type="checkbox"/>		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
TOWN <u>Takoma Park</u> LENGTH OF STAY (in this place) <u>6 days</u>		OR TOWN <u>Takoma Park</u> 17	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium & Hospital</u>		STREET ADDRESS (If rural give location) <u>1201 Kirk Lynn Ave</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
DECEASED: (Type or Print) <u>Henry (NMN) Gay</u>		OF DEATH: <u>7</u> <u>24</u> <u>1955</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (specify) <u>Married</u>		8. DATE OF BIRTH: <u>4-12-'05</u>	
9. AGE last birthday <u>50</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): <u>Barber</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Switzerland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer</u>	
13. FATHER'S NAME: <u>Riccardo Gay</u>		14. MOTHER'S MAIDEN NAME: <u>Christina Gamini</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Washington Sanitarium & Hospital</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>ACUTE Meningoencephalitis</u>		<u>8 days</u>	
ANTECEDENT CAUSE (S) (B) <u>Viruses of undetermined type</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) (Minute) (Second) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 17, 1955</u> , to <u>July 24, 1955</u> , that I last saw the deceased alive on <u>July 23, 1955</u> , and that death occurred at <u>1:50 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Russell B. Arnold</u>		DATE SIGNED <u>7-24-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/27/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cem.</u>		LOCATION (City, town, or county) (State) <u>Washington DC</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/27/55</u>		24. FUNERAL DIRECTOR <u>The J. H. Hines Co 2901-14th St NW</u>	
REGISTRAR'S SIGNATURE <u>J. H. Hines</u>		ADDRESS <u>2901-14th St NW</u>	

THE OCEANOGRAPH

1891

6842

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	LENGTH OF STAY (in this place) <u>9 weeks</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1602 Cody Drive</u>		STREET ADDRESS (If rural give location) <u>1602 Cody Drive</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>ZACHARIAH THOMAS GOLDSMITH</u>		OF DEATH <u>July 23</u> <u>19 55</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Dec. 27, 1887</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired (10 yrs.) Builder</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Builder</u>	
11. BIRTHPLACE (State or foreign country): <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>James S. Goldsmith</u>		14. MOTHER'S MAIDEN NAME: <u>Catherine Aldridge</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Spring, Md.</u> <u>Mrs. Robt. W. Corzine, 1602 Cody Drive, Silver</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>		<u>7 mo</u>	
ANTECEDENT CAUSE (B) <u>Arteriosclerosis</u>		<u>3 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Booster's heart failure</u>			
19A. DATE OF OPERATION: <u>None</u>		19B. MAJOR FINDINGS OF OPERATION: <u>None</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-8</u> , 19 <u>55</u> to <u>7-23</u> , 19 <u>55</u> that I last saw the deceased alive on <u>7-22, 1955</u> , and that death occurred at <u>6:40 AM</u> , from the causes and on the date stated above.			
SIGNED <u>John H. Rogers</u> M. O. <u>1918 University Ave</u> ADDRESS <u>7-23-55</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 26, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-25-55</u>		REGISTRAR'S SIGNATURE <u>James C. Otter</u>	
24. FUNERAL DIRECTOR <u>Warner C. Pumphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FORM NO. 1

796

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6777

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>MONTGOMERY</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>PRINCE GEORGES</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>17 TAKOMA PARK</u>	LENGTH OF STAY (in this place) <u>1 1/2 yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>BRENTWOOD</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9. OAK HAVEN REST HOME</u>		STREET ADDRESS (If rural give location) <u>3600 JAYLOK ST.</u>	
3. NAME OF DECEASED (Type or Print) <u>ROSE M. GRAVES</u>		4. DATE OF DEATH: (Month) <u>7</u> (Day) <u>17</u> (Year) <u>1955</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MAY 11-1888</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10B. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>67</u> yrs	11. BIRTHPLACE (State or foreign country): <u>WOODSTOCK, MD.</u>
13. FATHER'S NAME <u>Joseph Werkle</u>	14. MOTHER'S MAIDEN NAME: <u>Mary Seeman</u>	17. INFORMANT & ADDRESS: <u>Thomas E. Graves, Same old</u>	12. CITIZEN OF WHAT COUNTRY?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>	16. SOCIAL SECURITY NO. <u>unknown -</u>	18. MEDICAL CERTIFICATION	
F. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>332X</u>		<u>2 days</u>	
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Old cerebral thrombosis, began her heart</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1950</u> , to <u>7/17/1955</u> that I last saw the deceased alive on <u>7/14/1955</u> and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>E. W. Hobbs</u>		DATE SIGNED <u>7/17/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>7-20-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		LOCATION (City, town, or county) (State) <u>Prince Geo Co. Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>July 17-1955</u>		24. FUNERAL DIRECTOR ADDRESS <u>NALLEYS Funeral Home 3200 R. Island Ave., Mt. Rainier, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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C. 1000000

CERTIFICATE OF DEATH

Reg. Dist. No. 218

Item 9, Film 185 8-16-55 et

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) Rural
 OR TOWN Manassas LENGTH OF STAY (in this place) 4 weeks
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Manassas

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Montgomery
 CITY (If outside corporate limits, write RURAL and give nearest town) Manassas
 OR TOWN Manassas
 STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

GEORGEEMORYGRAY

4. DATE OF DEATH:

(Month)

(Day)

(Year)

291955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE (last birthday): IF UNDER 1 YEAR: IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442X

Immediate cause

(a) Uremia

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last.

(b) Arteriosclerotic Cardiovascular Renal Disease

DUE TO

(c)

Interval Between Onset And Death

5 days10 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb, 1955, to 29 July, 1955, that I last saw the deceasedalive on 28 July, 1955, and that death occurred at 8 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Edmond SmithM.D.BARNESVILLE30 July 55

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

July 30, 1955Alfred S. CookeW. W. BarbourBarnesville

MARGIN RESERVED FOR BINDING

1000

1000

1000

1000

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> TOWN <u>Bethesda</u> LENGTH OF STAY (in this place) <u>34 days</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center National Institutes of Health</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Virginia</u> COUNTY <u>Alexandria</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Alexandria</u> <u>83X-3</u> STREET ADDRESS (If rural give location) <u>2 Enfield Drive</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Dorothy E. Gruff</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July 11, 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>August 4, 1923</u>
9. AGE last birthday IF UNDER 1 YEAR <u>31</u> yrs. <u>11</u> Months <u>7</u> Days		10. IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>--</u>	
11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Fred Pacitti</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Pacacio</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>187-18-8025</u>	
17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>2-IX</u> IMMEDIATE CAUSE (A) <u>Lobular pneumonia</u> DUE TO ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Hodgkins disease</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>none</u>		19B. MAJOR FINDINGS OF OPERATION <u>none</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>None</u>	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 7, 1955</u> , to <u>July 11, 1955</u> , that I last saw the deceased alive on <u>July 11, 1955</u> , and that death occurred at <u>1:45 PM</u> , from the causes and on the date stated above. SIGNATURE <u>Les M. Miller Jr.</u> ADDRESS <u>The Clinical Center National Institutes of Health</u> DATE SIGNED <u>July 11, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-14-55</u> NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u> LOCATION (City, town, or county) (State) <u>Delaware Co. Veadon Pa.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-12-55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> 24. FUNERAL DIRECTOR ADDRESS <u>Robert A. Humphrey Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUNNAY N. D.

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6846

CERTIFICATE OF DEATH

Reg. Dist. No. 215 06827

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>District of Columbia</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Bethesda rural</u>	LENGTH OF STAY (in this place) <u>2 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington, D.C.</u>	<u>47X-3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>		STREET ADDRESS (If rural give location) <u>640 G Street, N.E.</u>	✓
3. NAME OF DECEASED: (First) (Middle) (Last) <u>James Earl HADEN</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>July 1 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	8. DATE OF BIRTH: <u>12-1-88</u>	9. AGE last birthday <u>66 yrs.</u>
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clerk</u>	
10B. KIND OF BUSINESS OR INDUSTRY: <u>Grocery Store</u>		11. BIRTHPLACE (State or foreign country): <u>Washington, D.C.</u>	
13. FATHER'S NAME: <u>Thomas HADEN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
14. MOTHER'S MAIDEN NAME: <u>Alice BIGGS</u>		17. INFORMANT & ADDRESS: <u>Sister Mary H. AUSTIN</u> <u>Lee Gardens, Arlington, Virginia</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>WW I</u>		19. SOCIAL SECURITY No. <u>577-48-1158</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Ventricular fibrillation</u>		<u>15 min</u>	
ANTECEDENT CAUSE (B) <u>Coronary atherosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>1</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>29 June, 1955</u> , to <u>1 July, 1955</u> , that I last saw the deceased alive on <u>1 July</u> , 1955, and that death occurred at <u>8:15 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>F. H. CARY LT MC USN</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
DATE THEREOF <u>6 July 1955</u>		LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2 July 1955</u>		24. FUNERAL DIRECTOR ADDRESS <u>S.H. HINES 2901 14th ST, NW, WDC</u>	

U. S. DEPARTMENT OF THE ARMY

SSA

OFFICE OF THE ADJUTANT GENERAL

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6847

06898

Reg. Dist. No. 216

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Cabin John</u>				TOWN <u>Cabin John</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Riverside Dr.</u>				STREET ADDRESS <u>Riverside Drive</u> (If rural, give location)			
3. NAME OF DECEASED: (First) <u>DAVID</u>		(Middle) <u>V.</u>		(Last) <u>HALL</u>		4. DATE OF DEATH (Month) <u>July</u> (Day) <u>4</u> (Year) <u>19 55</u>	
6. SEX: <u>Male</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>Aug. 8, 1890</u>		9. AGE last birthday: <u>64</u> yrs <u>10</u> Months <u>26</u> Days	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Maint. US Gov</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Government</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>213-16-2084</u>		17. INFORMANT & ADDRESS: <u>Step-son John W. Skinner-Box 346 Gaithersburg, Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>Interval</u> <u>2-4</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Bruchard</u>		M. D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>5-4-55</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>7-8-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem</u>		LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
DATE REC'D BY LOCAL REG. <u>7/6/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert C. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06899
6848 CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE _____		COUNTY _____	
CITY (If outside corporate limits, write RURAL, and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL, and give nearest town)			
56 TOWN <u>Silver Spring, Md.</u>		1 day		OR TOWN <u>Washington, D. C.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Paint Branch Nursing Home</u>				STREET ADDRESS (If rural give location) <u>5413 - 5th St., N. W.</u>			
3. NAME OF DECEASED: (Type or Print) <u>JAMES EDWARD HALL</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>July 26 1955</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>		8. DATE OF BIRTH: <u>May 14, 1903</u>	
9. AGE last birthday: <u>52</u> yrs		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Mechanic</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Automobile</u>		9. AGE last birthday: <u>52</u> yrs	
11. BIRTHPLACE (State or foreign country): <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME: <u>Joseph Edward Hall</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Minor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NI</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>579-02-5580</u>			
17. INFORMANT & ADDRESS: <u>Miss Mildred E. Hall, Washington, D. C.</u>				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>GENERALIZED CARCINOMATOSIS</u>				8 mos			
ANTECEDENT CAUSE (B) <u>CARCINOMA OF PANCREAS</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION <u>7-27-55</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OR INJURY street, office bldg., etc)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 25, 1954</u> , to <u>July 26, 1955</u> , that I last saw the deceased alive on <u>July 23, 1955</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>George P. George</u>		ADDRESS		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 28, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Oakwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Falls Church, Virginia</u>	
DATE PEC'D BY LOCAL REGISTRAR <u>7-27-55</u>		REGISTRAR'S SIGNATURE <u>Frances Potter</u>		24. FUNERAL DIRECTOR <u>Wm. E. Pumphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

6849 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06830
 Item 14 film 184 7-27-55 et
CERTIFICATE OF DEATH

Reg. Dist. No. 2.0

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Montgomery</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Bethesda</i>		<i>14 days</i>		TOWN <i>Silver Spring</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Suburban Hosp.</i>				STREET ADDRESS (If rural give location) <i>10207 Haywood Dr.</i>			
3. NAME OF DECEASED: (Type or Print) <i>Orlando Graham</i>				4. DATE OF DEATH: (Month) (Day) (Year) <i>July 19 1955</i>			
5. SEX: <i>Male</i>		6. COLOR OR RACE: <i>white</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>		8. DATE OF BIRTH: <i>October 28 - 1873</i>	
9. AGE last birthday: <i>82</i> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Pharm.</i>		11. BIRTHPLACE (State or foreign country): <i>Washington - D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Columbus Hall</i>				14. MOTHER'S MAIDEN NAME: <i>Unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS: <i>Brother L. Hall</i>				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
153X IMMEDIATE CAUSE (A) <i>Carcinoma of Colon</i>				8-10 mos			
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Feb</i> , 1954 to <i>19 July 1955</i> , that I last saw the deceased alive on <i>19 July</i> , 1955, and that death occurred at <i>9:20 P.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>William D. Lind</i>				ADDRESS <i>Silver Spring, Md.</i>		DATE SIGNED <i>7-7-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				DATE THEREOF <i>7/22/55</i>		NAME OF CEMETERY OR CREMATORY <i>Glenwood Cems.</i> LOCATION <i>Wash. D.C.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>7-20-55</i>		REGISTRAR'S SIGNATURE <i>Benjamin M. ...</i>		24. FUNERAL DIRECTOR		ADDRESS <i>The S.W. Thiele Co 2901-14th St. N.W. Wash. D.C.</i>	

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CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montg</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Gaithersburg. Rural</u>		LENGTH OF STAY (in this place) <u>6yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Gaithersburg</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS <u>Rout #3</u> (If rural give location) <u>/</u>			
3. NAME OF DECEASED: (First) <u>Mary</u> (Middle) <u>Elizabeth</u> (Last) <u>Hanger</u>				4. DATE OF DEATH: (Month) <u>7</u> (Day) <u>4</u> (Year) <u>1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH: <u>Mar 20-1874</u>	
9. AGE last birthday: <u>81</u> yrs.		10. MONTHS <u>3</u> DAYS <u>14</u> HOURS <u></u> MIN. <u></u>		11. BIRTHPLACE (State or foreign country): <u>Petersburg. W Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Home work</u>			
13. FATHER'S NAME: <u>Floyd D. Hanger</u>				14. MOTHER'S MAIDEN NAME: <u>Mary C. Keptlinger</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <u></u>			
17. INFORMANT & ADDRESS: <u>Mr Corbett V. Hanger, Gaithersburg. Md.</u>							
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
157X Immediate cause (a) <u>Carcinoma of Pancreas</u>						<u>2yrs</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u></u>							
(c) <u></u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u></u>				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT (Specify) <u></u>				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. SUICIDE (Specify) <u></u>				21. PLACE (Home, farm, factory, street, office bldg., etc.) <u></u>			
21. HOMICIDE (Specify) <u></u>				21. (CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u></u>				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
HOW DID INJURY OCCUR? <u></u>							
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>55</u> , to <u>4 July</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3 July</u> , 19 <u>55</u> , and that death occurred at <u>1:13 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>6 July 55</u>			
23. BURIAL, CREMATION, REMAINS (Specify) <u>Buried</u>				DATE THEREOF <u>7-6-55</u>			
NAME OF CEMETERY OR CREMATORY <u>Maple Hill</u>				LOCATION (City, town, or county) (State) <u>Petersburg. W. Va.</u>			
DATE REC'D BY LOCAL REGISTRAR <u>July 5, 1955</u>				REGISTRAR'S SIGNATURE <u>[Signature]</u>			
24. FUNERAL DIRECTOR <u>Ernest C. Gartner, Gaithersburg, Md.</u>				ADDRESS <u></u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PORTLAND, O. S.

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CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Tenn.</u>		COUNTY <u>79</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mascot</u>			
X TOWN <u>Bethesda</u>		<u>14</u> days					
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center, NIH</u>				STREET ADDRESS (If rural give location) <u>Route 1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Leon Cromwell Hargis</u>				<u>July 18 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Jan. 8, 1922</u>	<u>33</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Mechanic</u>		<u>Auto Service</u>		<u>Tenn.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Charlie Hargis</u>				<u>Bessie Webster</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>Yes</u> (If Yes, give war or dates of service) <u>W.W.II</u>				<u>not available</u>		<u>The medical record, The Clinical Center</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE				(A) <u>Respiratory failure</u>			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <u>Carcinoma of testicle with massive metastases to lungs, brain, adrenal glands, abdominal nodes</u>			
				(C) <u>XXXXXX</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							

19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>July 7, 1955</u>				<u>Metastatic tumor, rt. parietal region ; Metastatic tumor, occipital region</u>			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
<input type="checkbox"/>		<u>None</u>		<u>INJURY OCCUR?</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-4-55</u> , 19 <u>55</u> , to <u>7-18-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 18</u> , 19 <u>55</u> , and that death occurred at <u>9:15 P.</u> M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Charles E. Wells</u>		<u>M.D. The Clinical Center, NIH</u>		<u>7/19/55</u>			
23. BURIAL, CREMATION, REMOVAL, (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-22-55 ?</u>		<u>Knockville</u>		<u>Tenn.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7-20-55</u>		<u>Bessie M. Thompson</u>		<u>Deal Funeral Home</u>		<u>4812 Georgia Ave. N.W. Washington, D.C.</u>	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>		STREET ADDRESS (If rural give location) <u>9308 Milroy Place</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
Edwin Rea Harkness		July 19 1955	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Jan. 18, 1886</u>
		9. AGE last birthday <u>69</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>gen. accounting - U.S. Government</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): <u>Illinois</u>
13. FATHER'S NAME: <u>Edwin R. Harkness</u>		14. MOTHER'S MAIDEN NAME: <u>Belle Mettler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Marge Harkness 9308 Milroy Place, Bethesda</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>585X</u> <u>thrombus, cardiac failure</u>			
ANTECEDENT CAUSE (B) <u>peritonitis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>dangerous myocardial work perforation</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>infectious, previous perforation</u>			
19A. DATE OF OPERATION. <u>7-10-55</u>		19B. MAJOR FINDINGS OF OPERATION <u>perforated small intestine, peritonitis</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While at work Not while at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7-10-55</u> to <u>7-19-55</u> , that I last saw the deceased alive on <u>7-19-55</u> , and that death occurred at <u>8:10 AM</u> from the causes and on the date stated above.			
SIGNATURE <u>John O. Robb (M)</u>		ADDRESS <u>7130 M. Georgia, Bethesda, Md.</u>	
DATE SIGNED <u>7-19-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial transit</u>		DATE THEREOF <u>7-21-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Elmwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Peoria Co. Illinois</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-20-55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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CERTIFICATE OF DEATH

Reg. Dist. No. 214

Montgomery Co. Md. Montgomery Co. Md.

1. PLACE OF DEATH: COUNTY <u>Montgomery</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Montg.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>56 Cedar Creek</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Henderson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Edwin Rd Silver Spring Md.</u>				STREET ADDRESS <u>10,600 Nesh Place</u>	
3. NAME OF DECEASED (Type or Print) <u>Maude</u>		(First) (Middle) <u>MAY</u>		(Last) <u>Harris</u>	
4. DATE OF DEATH <u>July 30 1987</u>		(Month) (Day) (Year)			
5. SEX <u>Female</u>		6. COLOR OR R <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	
8. DATE OF BIRTH <u>Feb 24 1925</u>		9. AGE last birthday <u>79 yrs.</u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>South</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Alfred May</u>		14. MOTHER'S MAIDEN NAME <u>JULIA ESTELLE TYLER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT AND ADDRESS <u>Frank Harris Rawlings</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause 422.2	(a) myocarditis	3 wks
Antecedent cause(s)	Virus pneumonia	190
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)...	

II. OTHER SIGNIFICANT CONDITIONS (c) ...
Conditions contributing to the death but not
related to the disease or condition causing death.

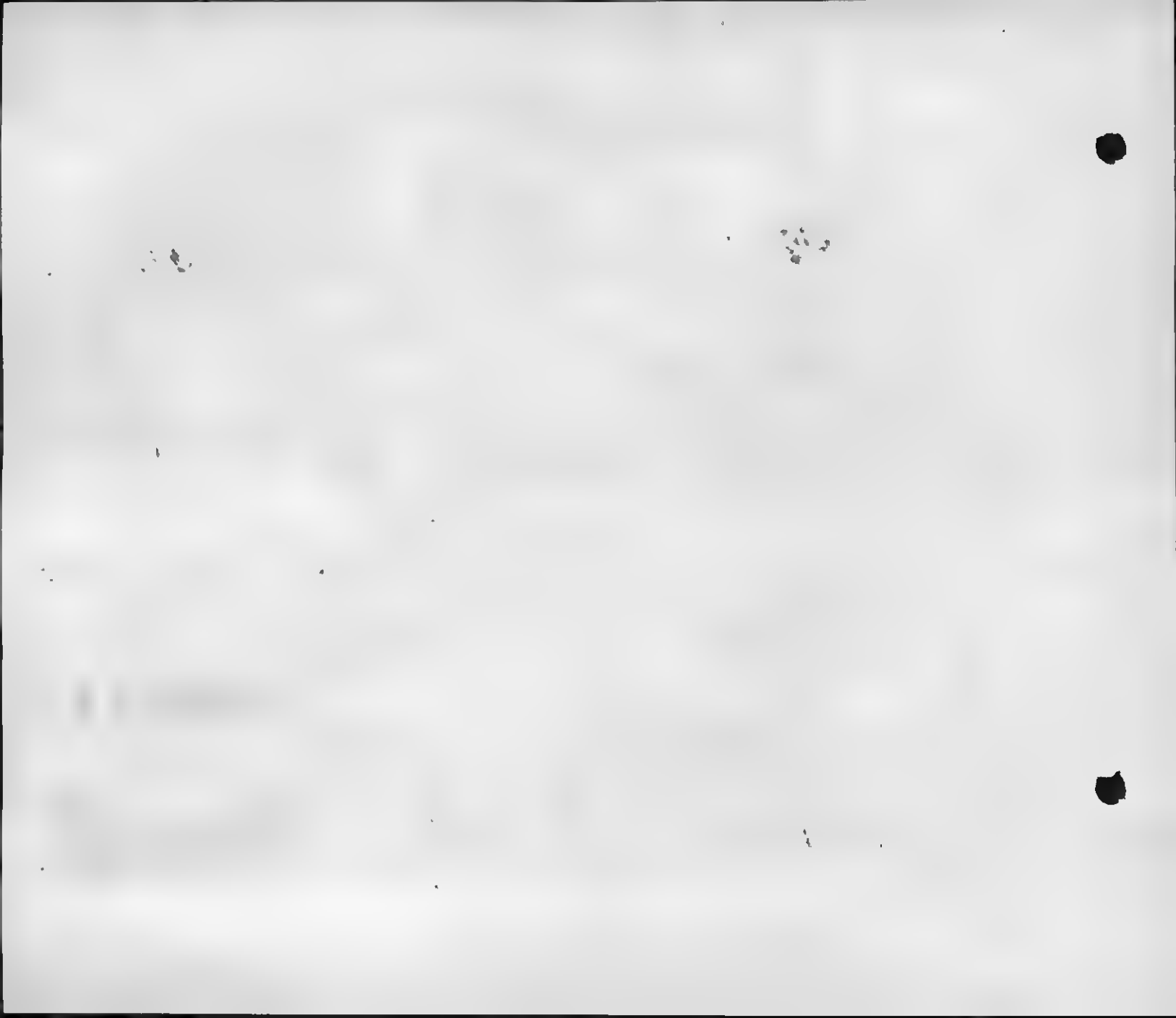
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
								Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY)	(STATE)
TIME (Month) (Day) (Year)		(Hour)	INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?				
OF INJURY		m.							

22. I hereby certify that I attended the deceased from 6-30, 1900 to July 30, 1900, that I last saw the deceased alive on 7-30, 1900, and that death occurred at 220-P m., from the causes and on the date stated above.

SIGNATURE A. L. Green (Degree or title) ADDRESS M. D. Cedar Creek, Ont. Can. DATE SIGNED Aug 1, 1900

23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE <i>Aug. 2, 1955</i>	NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>	LOCATION (City, town, or county) <i>Washington, D. C.</i>	(State)
DATE REC'D BY LOCAL REG. <i>7-21-55</i>	REGISTRAR'S SIGNATURE <i>Frances Tetter</i>	24. FUNERAL DIRECTOR <i>Waxner Co. Pumpfuny</i>	ADDRESS <i>Silver Spring, Md.</i>	

MARGIN RESERVED FOR BINDING



6851

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural give location) <u>3910 Dresden St</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)	4. DATE (Month) (Day) (Year)		
<u>Naomi H. Hartshorn</u>	<u>July 27 1955</u>		
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>4/8/98</u>
			9. AGE last birthday: <u>57</u> yrs. <u>3</u> Months <u>19</u> Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
<u>Housewife</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME: <u>Joseph Haller</u>		14. MOTHER'S MAIDEN NAME: <u>Lucretia Wilcoxon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>1</u>		<u>Hosmer P. Hartshorn</u>	
17. INFORMANT & ADDRESS:			
<u>Hosmer P. Hartshorn</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
477.2 IMMEDIATE CAUSE (A) <u>cardiac arrest</u>			<u>5 min</u>
ANTECEDENT CAUSE (B) <u>chronic myocarditis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>chronic emphysema</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>10 min excision of rectal adenoma</u>			<u>20 min</u>
19A. DATE OF OPERATION: <u>7/27/55</u>	19B. MAJOR FINDINGS OF OPERATION: <u>Rectal adenoma</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1955</u> , to <u>1955</u> , that I last saw the deceased alive on <u>7/27</u> , 19 <u>55</u> , and that death occurred at <u>1240</u> P.M. from the causes and on the date stated above.			
SIGNATURE <u>John O. Robben MD</u>		ADDRESS <u>7930 Severn Ave S.S. Md</u>	DATE SIGNED <u>7-29-55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>7-30-55</u>	NAME OF CEMETERY OR CREMATORY <u>Parklawn Cem.</u>	LOCATION (City, town, or county) (State) <u>Rockville Montg.Co. Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>8/1/55</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>	ADDRESS <u>Bethesda, Md.</u>

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Breschart (Covner) was notified (m.g.)



6778

CERTIFICATE OF DEATH

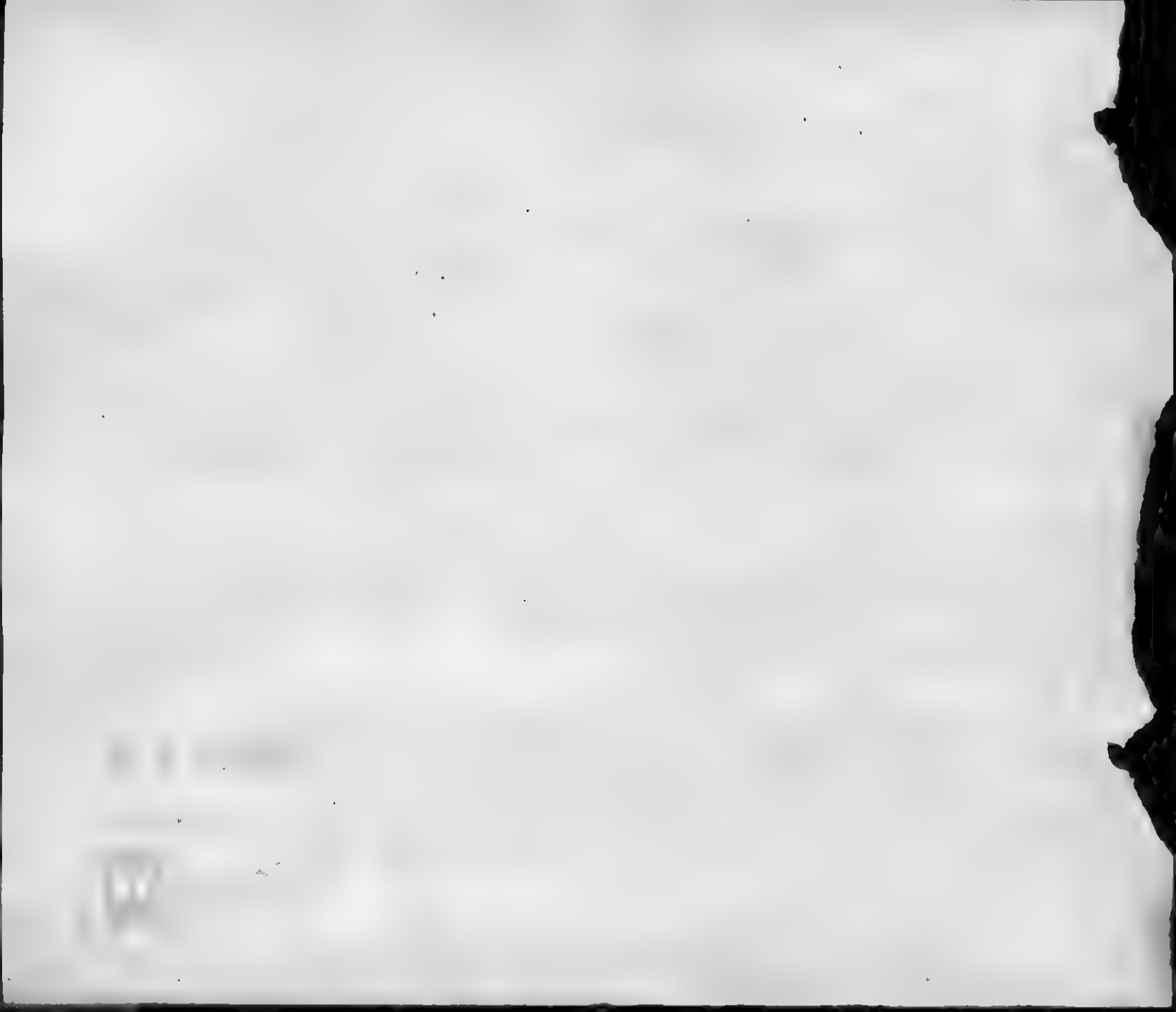
Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>MONTGOMERY</u> MARYLAND				STATE <u>MD</u> COUNTY <u>12-4-2</u>			
CITY (If outside corporate limits, write RURAL OR give nearest town) <u>17 TOWN TAKOMA PK.</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Havre de Grace</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>EBENTIDE SANIT</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>MARY ELLEN HEALY</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>7-7-1955</u>			
5. SEX <u>7</u>		6. COLOR OR RACE <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH: <u>May 18, 1924</u>	
9. AGE last birthday <u>81</u> yrs		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Days		12. IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>—</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>—</u>			
11. BIRTHPLACE (State or foreign country): <u>Havre de Grace</u>				12. CITIZEN OF WHAT COUNTRY: <u>US</u>			
13. FATHER'S NAME: <u>Thos. Healy</u>				14. MOTHER'S MAIDEN NAME: <u>Ann B. Magee</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>—</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT & ADDRESS: <u>Hosp. Records</u>							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>450.0</u> (A) <u>Renal Insufficiency</u>							
ANTECEDENT CAUSE (B) <u>Generalized Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Serubity</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)							
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			
21F. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <u>June 1955</u> , to <u>July 1955</u> , that I last saw the deceased alive on <u>July 7, 1955</u> , and that death occurred at <u>11:25 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Reynard A. Fitzgibbon</u>				ADDRESS <u>M. D. 9620 Old Bladensburg Rd</u>			
DATE SIGNED <u>7-8-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>				DATE THEREOF <u>7-11-55</u>			
NAME OF CEMETERY OR CREMATORY <u>Mt. Erin</u>				LOCATION (City, town, or county) (State) <u>Havre de Grace</u>			
DATE REC'D BY LOCAL REGISTRAR <u>July 8-1955</u>				REGISTRAR'S SIGNATURE <u>William Kocel</u>			
24. FUNERAL DIRECTOR <u>Gas. T. Ryan Inc.</u>				ADDRESS <u>317 Pa Ave W.B. 517 D.C.</u>			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1955 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06877											
CERTIFICATE OF DEATH											
Reg. Dist. No. 214											
Item 7, Film 184 7-25-55											
1. PLACE OF DEATH:						2. USUAL RESIDENCE (HOME) OF DECEASED.					
COUNTY <u>MONTGOMERY</u> MARYLAND						STATE <u>Dist 9</u> COUNTY <u>4th</u>					
CITY (If outside corporate limits, write RURAL and give nearest town)						CITY (If outside corporate limits, write RURAL and give nearest town)					
X TOWN <u>KENSINGTON</u>						TOWN <u>Washington</u>					
HOSPITAL OR INSTITUTION OR STREET ADDRESS						STREET ADDRESS (If rural give location)					
90 <u>CARROLL HALL</u>						<u>237 Mo. Ave N.W.</u>					
3. NAME OF DECEASED: (Type or Print)						4. DATE (Month) (Day) (Year)					
<u>HEURY C. HEDRICK</u>						OF DEATH: <u>July 15 1955</u>					
5. SEX <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>		8. DATE OF BIRTH: <u>DEC 26-1877</u>		9. AGE last birthday: <u>77</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Auto Wash & Repair Shop & Buellings</u>						10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>W</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Henry Clay Hedrick</u>						14. MOTHER'S MAIDEN NAME: <u>RENA Liskey</u>					
15. WAS DECEASED EVER IN U.S. Armed Forces? (Yes, no, or unk.) (If Yes, give war or dates of service)						16. SOCIAL SECURITY NO. <u>577-10-5678</u>		17. INFORMANT & ADDRESS: <u>HARRISON Bung Va</u>			
18. MEDICAL CERTIFICATION											
F DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH											
422.2 IMMEDIATE CAUSE (A) <u>ACUTE MYOCARDITIS</u>											
ANTECEDENT CAUSE (B) <u>CHRONIC PROSTATITIS</u>											
DISEASES OR CONDITIONS IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>CHRONIC MYOCARDITIS</u>											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>SENILITY</u>											
19A. DATE OF OPERATION:						19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)				21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>NONE</u> M.				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>MAY 7</u> , 1955, to <u>July 15 1955</u> , that I last saw the deceased alive on <u>July 15, 1955</u> , and that death occurred at <u>730P M.</u> from the causes and on the date stated above.											
SIGNATURE <u>Henry C. Hedrick</u>				ADDRESS <u>5206 NORWAY DR. CHEVY CHASE, MD.</u>				DATE SIGNED <u>July 15-1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF <u>7-19-55</u>		NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		LOCATION (City, town, or county) <u>Prince Geo Ind</u>		(State)	
DATE REC'D BY LOCAL REGISTRAR <u>July 18 1955</u>				REGISTRAR'S SIGNATURE <u>Francis Tetter</u>				24. FUNERAL DIRECTOR <u>2901-14th St. N.W. Wash. D.C.</u>			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8856

08888

Reg. Dist. No. 216

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>NC</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Broomont</u>		<u>30 min.</u>		TOWN <u>Durham</u> <u>728-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Feder Lane</u>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>Charles S.</u>		(Middle)		(Last) <u>Heflin</u>		(Month) (Day) (Year) <u>July 2 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>12-24-1910</u>		9. AGE last birthday: <u>44</u> yrs. <u>8</u> Months <u>8</u> Days <u>8</u> Hours <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Car Lot Attn</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Henry H. Heflin</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Fuller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>Yes</u>		17. INFORMANT & ADDRESS: <u>Hazel H. Dodson, sister</u> <u>815 Mary St. Durham, No. Carolina</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>929.8</u> Immediate cause (a) ... <u>Asphyxia</u> DUE TO Antecedent cause(s) (b) ... <u>drowning</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>Sudden</u> <u>death</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>Broomont</u>		21c. (City or town) (County) (State) <u>Monty</u> <u>MD</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7-2-55-12:53 A.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Was swimming in dam</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broesch</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-3-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		DATE THEREOF <u>7-3-55</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>7/4/55</u>		REGISTRAR'S SIGNATURE <u>Beattie M. Cooper</u>		24. FUNERAL DIRECTOR <u>Robert H. Humphrey</u> ADDRESS <u>Bethesda, Md.</u>			



10/1/1914

SS

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6857

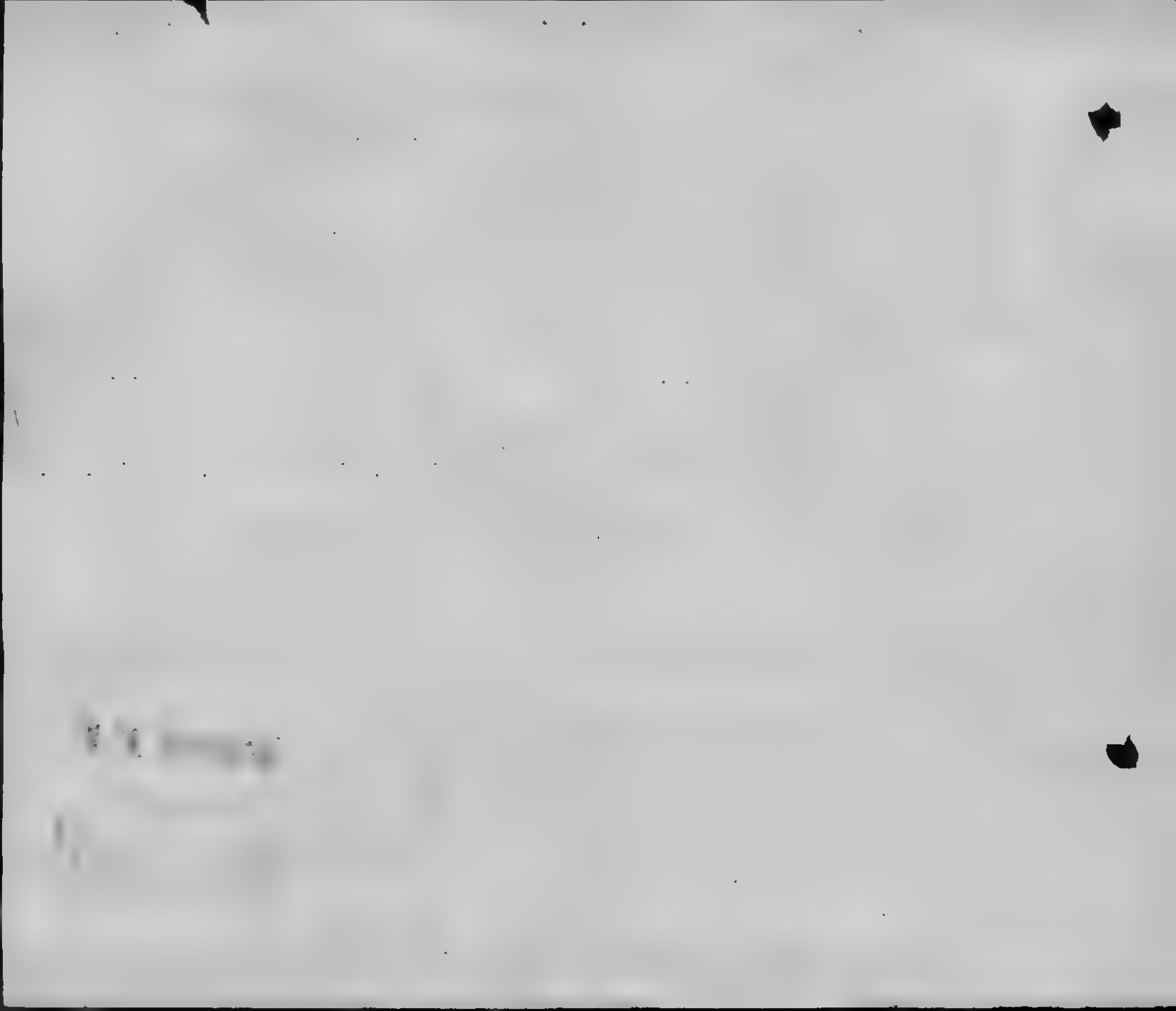
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 75

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>ethesda</u> Rural		2 days		TOWN <u>Midway Island</u> S.A. 2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural, give location) <u>59 Norris Drive</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
William Carol HEWITT				July 25 19 55			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: 9-29-26	
9. AGE last birthday: 28 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Mariner		11. BIRTHPLACE (State or foreign country): South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Mariner				10b. KIND OF BUSINESS OR INDUSTRY: U.S. Marines			
13. FATHER'S NAME: Epharm HEWITT				14. MOTHER'S MAIDEN NAME: Ora PASS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Yes ✓				17. INFORMANT & ADDRESS: Wife Wilhelmina HEWITT 39 Norris Dr. Midway Island, Quantico, Va.			
16. SOCIAL SECURITY No.: 10-21-53 to 7-25-55 Unknown				17. INFORMANT & ADDRESS: Wife Wilhelmina HEWITT 39 Norris Dr. Midway Island, Quantico, Va.			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							3 days
Immediate cause (a)..... Traumatic subdural hematoma with cerebral contusions and edema DUE TO Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c).....							
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION: 7-25-55							19b. MAJOR FINDING OF OPERATION:
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH							21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Residence</u>
21c. (City or town) (County) (State)							<u>Mr. Stafford - N.S.R.-1</u> <u>OK</u>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7-22-55</u> <u>11 P</u> <u>M</u>							21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
21f. HOW DID INJURY OCCUR? <u>Pedestrian struck by auto</u>							
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broschart</u>							CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> <u>7-25-55</u>
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial transit</u>							24. FUNERAL DIRECTOR ADDRESS
DATE THEREOF <u>7-25-55</u>							<u>7-25-55</u>
NAME OF CEMETERY OR CREMATORY <u>Pethel Cemetery</u>							<u>7557 Wisconsin Avenue, Bethesda, Maryland</u>
LOCATION (City, town, or county) (State) <u>Charleston, S.C.</u>							
DATE REC'D BY LOCAL REG <u>7-25-55</u>							REGISTRAR'S SIGNATURE <u>Mary E. Parrelly</u>



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06840
 6859 Items 7, 11, File 184 7-15-55 et
CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED.			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Olney</u>				OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<u>The Montgomery County General Hospital, Inc.</u>		STREET ADDRESS (If rural give location)			
				<u>1617 West Landvale Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>Alfred</u> <u>Howard</u>				OF DEATH: <u>July</u> <u>1</u> <u>1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>male</u>	<u>colored</u>	<u>Widowed</u>	<u>4/30/74</u>	<u>81</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>laborer</u>				<u>Maryland</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Greenberry Howard</u>				<u>Mary Prettyman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS:							
<u>Hospital Records</u>							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
440X IMMEDIATE CAUSE (A) <u>Uremia</u>						<u>10 day.</u>	
ANTECEDENT CAUSE (B) <u>Chronic nephritis</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arterio sclerosis</u>						<u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>DC</u>				<u>←</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/24/</u> , 1955, to <u>7/1/</u> , 1955, that I last saw the deceased alive on <u>7/1/</u> , 1955, and that death occurred at <u>12:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS <u>Sandy Spring Md</u> DATE SIGNED <u>7/1/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/3/55</u>		<u>Sandy Spring</u>		<u>Sandy Spring Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7-3-55</u>		<u>Kenneth B. Lawler</u>		<u>[Signature]</u>		<u>12 Snowden Rockville Md</u>	

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CERTIFICATE OF DEATH

Reg. Dist. No. 217....

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Montgomery</u>	MARYLAND		STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	LENGTH OF STAY (in this place) <u>2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		
TOWN <u>Rockville</u>			OR TOWN <u>Rockville</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rockville Hospital</u>			STREET ADDRESS (If rural give location)		
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE OF DEATH: (Month) (Day) (Year)		
<u>CORA DARLINE HOWARD</u>			<u>July 24 1955</u>		
5. SEX: <u>FEMALE</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Single</u>	8. DATE OF BIRTH: <u>JULY 24 1935</u>		
9. AGE last birthday: <u>20</u> yrs. Months <u>2</u> Days <u>2</u> Hours <u>1</u> Min.			10. BIRTHPLACE (State or foreign country): <u>Maryland</u>		
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME: <u>Kermit R. Howard</u>			14. MOTHER'S MAIDEN NAME: <u>Curtis Bernice Milton</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>+</u>			16. SOCIAL SECURITY NO. <u>---</u>		
17. INFORMANT & ADDRESS: <u>Kermit R. Howard</u>					
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE <u>760.0</u>					
(A) <u>Cerebral Hemorrhage</u>					<u>1 day</u>
ANTECEDENT CAUSE (S)					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.					
(B)					
DUE TO					
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION: <u>July 26, 1955</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 22, 1955</u> , to <u>July 24, 1955</u> , that I last saw the deceased alive on <u>July 24, 1955</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above.					
SIGNATURE <u>James P. Kern</u>		ADDRESS <u>Hamascus, Md.</u>		DATE SIGNED <u>July 24, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>July 26, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Seals Home Cemetery</u>	
LOCATION (City, town, or county) <u>Etchison</u>		(State) <u>MD</u>			
DATE REC'D BY LOCAL REGISTRAR <u>7-26-55</u>		REGISTRAR'S SIGNATURE <u>Beatrice B. Lawler</u>		24. FUNERAL DIRECTOR <u>Roy W. Barber</u>	
				ADDRESS <u>Gettysville</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 211

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Clarksburg</u>				TOWN <u>Clarksburg</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<u>Loward Avenue</u>		STREET ADDRESS (If rural, give location)		<u>Edward Avenue</u>	
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
(Type or Print) <u>RICHARD</u>		<u>L</u> <u>HOWARD</u>		<u>July 15</u>		<u>19 55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Aug. 25, 1899</u>	<u>55</u> yrs.	<u>10</u> Months	<u>20</u> Days	<u>Hours</u> <u>Mln.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Laborer</u>				<u>Maryland</u>		<u>U.S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>219-03-6211</u>		<u>Jessie J. Howard</u> <u>Son, Clarksburg, Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary occlusion</u>						<u>Sudden</u>	
DUE TO							
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause</u>							
DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY?	
						Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		M. D.		CHIEF MEDICAL EXAMINER		DATE SIGNED	
<u>Frank J. Broschart</u>				DEPUTY MEDICAL EXAMINER		<u>7-15-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-18-55</u>		<u>Neelsville, Maryland</u>		<u>Montgomery Co. Maryland</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>July 23, 1955</u>		<u>Della W. Burdette</u>		<u>Robert A. Humphrey</u>		<u>Bethesda, Md.</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	LENGTH OF STAY (in this place) <u>3 days 5 8/4 hrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase, Md.</u>	TOWN <u>Cherry Chase, Md.</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS <u>4300 Willow Lane</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>William Johnston Howard</u>		OF DEATH: <u>7-31</u> 19 <u>55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>10-31-97</u>
9. AGE last birthday <u>57</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
11. BIRTHPLACE (State or foreign country): <u>Pittsburg, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>William Bakewell Howard</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Johnston</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>World War II</u>		16. SOCIAL SECURITY No. <u>4300 Willow Lane, CC, Md.</u>	
17. INFORMANT'S ADDRESS: <u>Mrs. Margaret Howard - wife</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>442X</u>		<u>4 days</u>	
ANTECEDENT CAUSE (S)		<u>Cardio-vascular renal disease 5 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 27, 1955</u> to <u>July 31, 1955</u> , that I last saw the deceased alive on <u>July 30, 1955</u> , and that death occurred at <u>3:15 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>William B. Cousens</u>		DATE SIGNED <u>8/1/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8-2-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cen.</u>		LOCATION (City, town, or county) <u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>8/2/55</u>		24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>	
REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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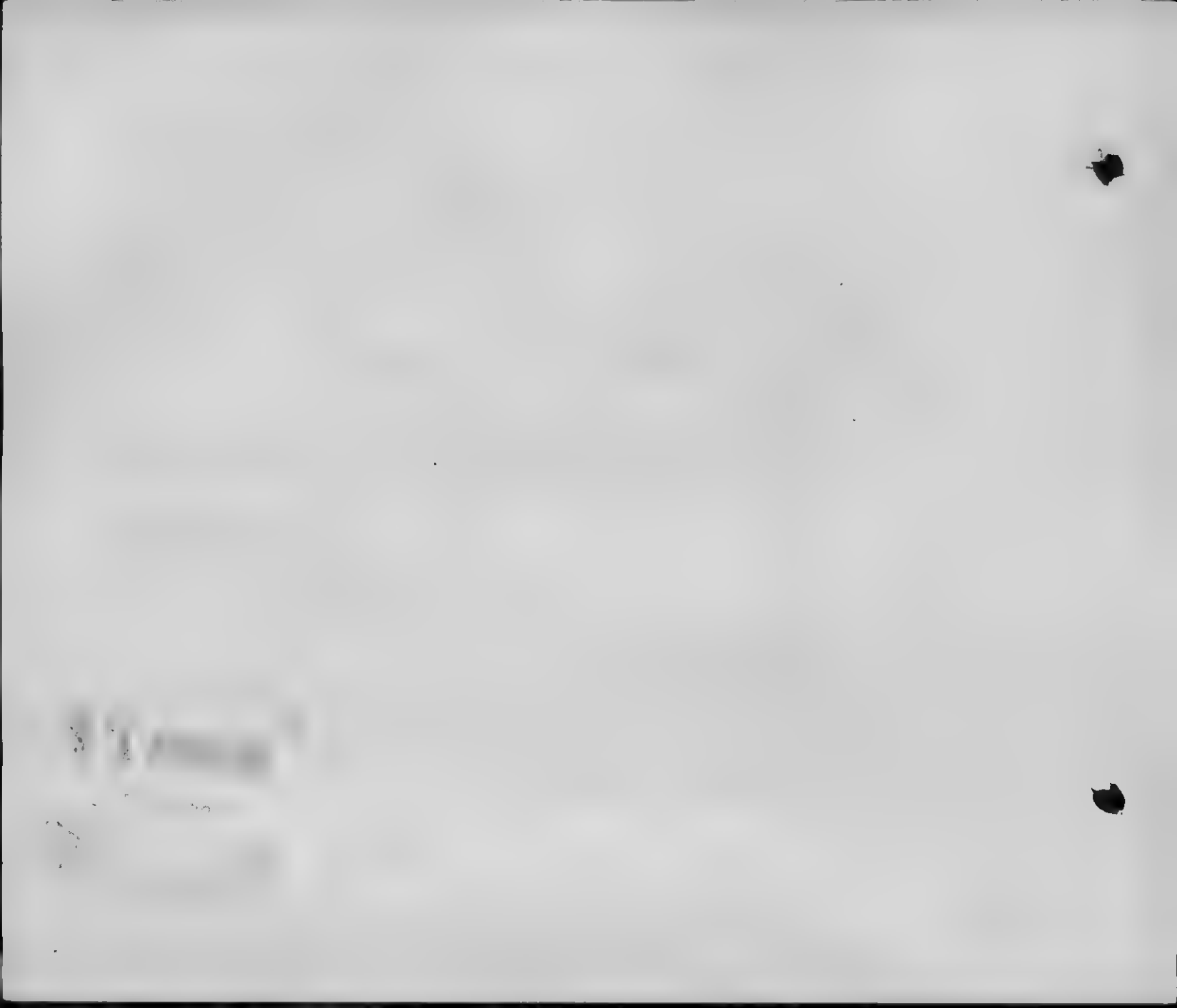
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 213

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Rockville</u>		LENGTH OF STAY (in this place) <u>E.O.A.</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Congressional Airport</u>				STREET ADDRESS (If rural, give location) <u>2214 Washington Avenue</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>W.</u> (Middle) <u>Raymond</u> (Last) <u>HUGHES</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 26, 19 55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Oct. 12, 1905</u>	9. AGE last birthday: <u>49</u> yrs.		IF UNDER 1 YEAR: <u>9</u> Months <u>14</u> Days IF UNDER 24 HRS. <u>14</u> Hours <u>55</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Wash. Eve. Star</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Clare R. Hughes</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Robe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>578-09-8958</u>		17. INFORMANT & ADDRESS: <u>Mary W. Hughes - Same as Item #2</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>Sudden</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broschart</u>		M. D. <u>Robert A. Campbell</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-26-55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>7/28/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>Prince George Maryland</u>	
DATE REC'D BY LOCAL REG. <u>7/27/55</u>		REGISTRAR'S SIGNATURE <u>Laurel H. Keator</u>		FUNERAL DIRECTOR <u>Robert A. Campbell</u>		ADDRESS <u>Bethesda, Md.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06845
6862 CERTIFICATE OF DEATH Reg. Dist. No. 215

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Washington, D.C.</u>		COUNTY <u>Washington, D.C.</u>	
CITY (If outside corporate limits, write RURAL, OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL, OR and give nearest town)		CITY (If outside corporate limits, write RURAL, OR and give nearest town)	
TOWN		3 Mo. 27 Days		TOWN <u>District of Columbia</u>		TOWN <u>District of Columbia</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Hospital,</u>		<u>Bethesda, Md.</u>		STREET ADDRESS (If rural give location)		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		5. DATE (Month) (Day) (Year)		6. DATE (Month) (Day) (Year)	
Cordell (n) HULL		July 23 1955		July 23 1955		July 23 1955	
5. SEX: Male		6. COLOR OR RACE: Cauc.		7. SINGLE, MARRIED, WIDOWED, DIVORCED: Widowed		8. DATE OF BIRTH: 2 OCT 1871	
9. AGE last birthday: 83 yrs.		10. AGE last birthday: 83 yrs.		11. AGE last birthday: 83 yrs.		12. AGE last birthday: 83 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
U.S. Government		State Department		Tennessee		US	
13. FATHER'S NAME: William HULL				14. MOTHER'S MAIDEN NAME: Elizabeth RILEY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT & ADDRESS Mrs. Katherine ETRIDGE (Neice) Same as item 2				18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
443X IMMEDIATE CAUSE				Hypertensive Cardiovascular Disease 10 yrs			
ANTECEDENT CAUSE (B)				Anteriodiabetic General 10 yrs			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.				Diabetes mellitus 30 yrs			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AD OPS?? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 26 Mar, 1955, to 23 Jul, 1955 that I last saw the deceased alive on 23 Jul, 1955, and that death occurred at 9:00A.M. from the causes and on the date stated above.							
J. W. FLYNN LT MC USN U. S. Naval Hospital, DMMC, Bethesda, Maryland 22 July 1955							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		26 Jul 1955		Cathedral Cemetery		Washington, D.C.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
23 July 1955		Mary E. Gennelly		Gawler's Funeral Home		1756 Penn Ave., Washington, D.C.	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THE UNIVERSITY

1955



6863

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<input checked="" type="checkbox"/> TOWN <u>Olney</u>	<u>22</u> days	TOWN <u>Rockville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>Montgomery County General Hospital, Inc.</u>		<u>Manor Club</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(Type or Print)	(First) (Middle) (Last)	(Month) (Day) (Year)	
<u>Don</u>	<u>R.</u>	<u>July 17</u>	<u>19 55</u>
<u>Hutchison</u>			
5. SEX:	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>12/21/1894</u>
9. AGE last birthday	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		
<u>60</u> yrs.	<u>Tax Attorney & Accountant</u>		
11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?		
<u>Iowa</u>	<u>U.S.A.</u>		
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>John R. Hutchison</u>		<u>Jessie Paris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>No</u>		<u>Unknown</u>	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
<u>Hospital Record</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
144X IMMEDIATE CAUSE		<u>1 yr</u>	
ANTECEDENT CAUSE (S)		<u>6 mos</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Carcinoma Soft Palate</u>			
DUE TO			
(B) <u>Small Intestines</u>			
DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
<u>L</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>April 1955</u>		<u>Carcinoma Soft Palate, with involvement of lymph nodes</u>	
20. AUTOPSY?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>6/22/1955</u> , to <u>7/17/1955</u> , that I last saw the deceased alive on <u>7/14/1955</u> , and that death occurred at <u>7:43a</u> M, from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>7/17/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Parklawn Cemetery</u>	
DATE REC'D BY LOCAL REGISTRAR		LOCATION (City, town, or county) (State)	
<u>7-19-55</u>		<u>Montgomery County, Maryland</u>	
REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
<u>Gertrude B. Lawler</u>		<u>Libner E. Pumphrey</u>	
		ADDRESS	
		<u>Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 2 3 4 5



JUL 5 - 1955

MARGIN RESERVED FOR BINDING

VS. A15 - 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06847

6779

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		LENGTH OF STAY (in this place) <u>6 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Sanitarium & Hospital</u>				STREET ADDRESS (If rural, give location) <u>9402 Russell Road</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Theresa Sarah Irwin</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>7-5-1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>		8. DATE OF BIRTH: <u>10-7-01</u>	
9. AGE last birthday: <u>53</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Hswf.</u>		11. BIRTHPLACE (State or foreign country): <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME: <u>Frank Vernon</u>				14. MOTHER'S MAIDEN NAME: <u>Rose Flecknoe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO: <u>none</u>			
17. INFORMANT & ADDRESS: <u>Hospital Record</u>							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>581.0 Hepatic Coma, terminal</u>						<u>3 days</u>	
ANTECEDENT CAUSE (S) (B) <u>Cirrhosis of liver, severe</u>						<u>4 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 1953, to <u>July 5</u> , 1955, that I last saw the deceased alive on <u>July 5</u> , 1955, and that death occurred at <u>6:58 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>George B. Patrick</u>		M.D. <u>8700 Eylesville</u>		DATE SIGNED <u>7-5-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/8/55</u>		NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-14-55</u>		REGISTRAR'S SIGNATURE <u>J. Jackson C. Wood</u>		24. FUNERAL DIRECTOR <u>Warner E. Humphrey</u>		ADDRESS <u>8434 Ga. Ave. Silver Spring, Md.</u>	

RECEIVED

NOV 10 1955

LIBRARY

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06848

6864

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Montgomery</u>	MARYLAND	LENGTH OF STAY (in this place)	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)			CITY (If outside corporate limits, write RURAL and give nearest town)		
TOWN <u>Olney</u>		<u>48 minutes</u>	OR TOWN <u>Laytonsville</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Montgomery County General Hospital, Inc.</u>			STREET ADDRESS (if rural give location)		
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE (Month) (Day) (Year) OF DEATH		
<u>Jackson</u>			<u>July 30 1955</u>		
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>7/30/55</u>	9. AGE last birthday yrs	IF UNDER 1 YEAR Months Days Hours Mins
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME: <u>Charlotte Jackson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT & ADDRESS: <u>Hospital Records</u>					
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE (A) <u>Bilateral atelectasis</u>					<u>45 minutes</u>
ANTECEDENT CAUSE (S)					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.					
(B) DUE TO					
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7/30</u> , 19 <u>55</u> , to <u>7/30</u> , 19 <u>55</u> that I last saw the deceased alive on <u>7/30</u> , 19 <u>55</u> , and that death occurred at <u>4/30</u> M, from the causes and on the date stated above.					
SIGNATURE <u>James E. Kern M.D.</u>		ADDRESS <u>M.D. Homersley, Md.</u>		DATE SIGNED <u>7/30/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>Aug 1 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Brook Grove and Laytonsville Md</u>	
LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR ADDRESS <u>Ray W Barber Laytonsville, Md</u>			
DATE REC'D BY LOCAL REGISTRAR <u>7-31-55</u>		REGISTRAR'S SIGNATURE <u>Gertrude B Lawler</u>			

1055 AUG 8

U. S. V.

06849

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 214

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Montgomery</u>	MARYLAND		STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write OR and give nearest town)	LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)		
TOWN <u>17 Takoma Park</u>	<u>13 8 hrs.</u>		TOWN <u>Silver Spring</u>	<u>56</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Sanitarium Hospital</u>			STREET ADDRESS (If rural, give location) <u>S. Stewart Lane</u>		
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First)	(Middle)	(Last)	(Month)	(Day)	(Year)
<u>George</u>	<u>Preston</u>	<u>Jackson</u>	<u>7</u>	<u>19</u>	<u>55</u>
5. SEX: <u>Male</u>			6. COLOR OR RACE: <u>Colored</u>		
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>			8. DATE OF BIRTH: <u>2-27-26</u>		
9. AGE last birthday: <u>29</u> yrs.			10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>19</u> Hours <u>55</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Butcher</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>-</u>		
11. BIRTHPLACE (State or foreign country): <u>Ind.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME: <u>David Jackson</u>			14. MOTHER'S MAIDEN NAME: <u>Louise Matthews</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.: <u>-</u>		
17. INFORMANT & ADDRESS: <u>Hospital Records</u>					

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) .. <u>Cerebral hemorrhage</u>	DUE TO	
Antecedent cause(s) (b) .. <u>Multiple fractures of skull</u>	DUE TO	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		<u>39 hrs.</u>

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fracture Rt ankle</u>	
--	--

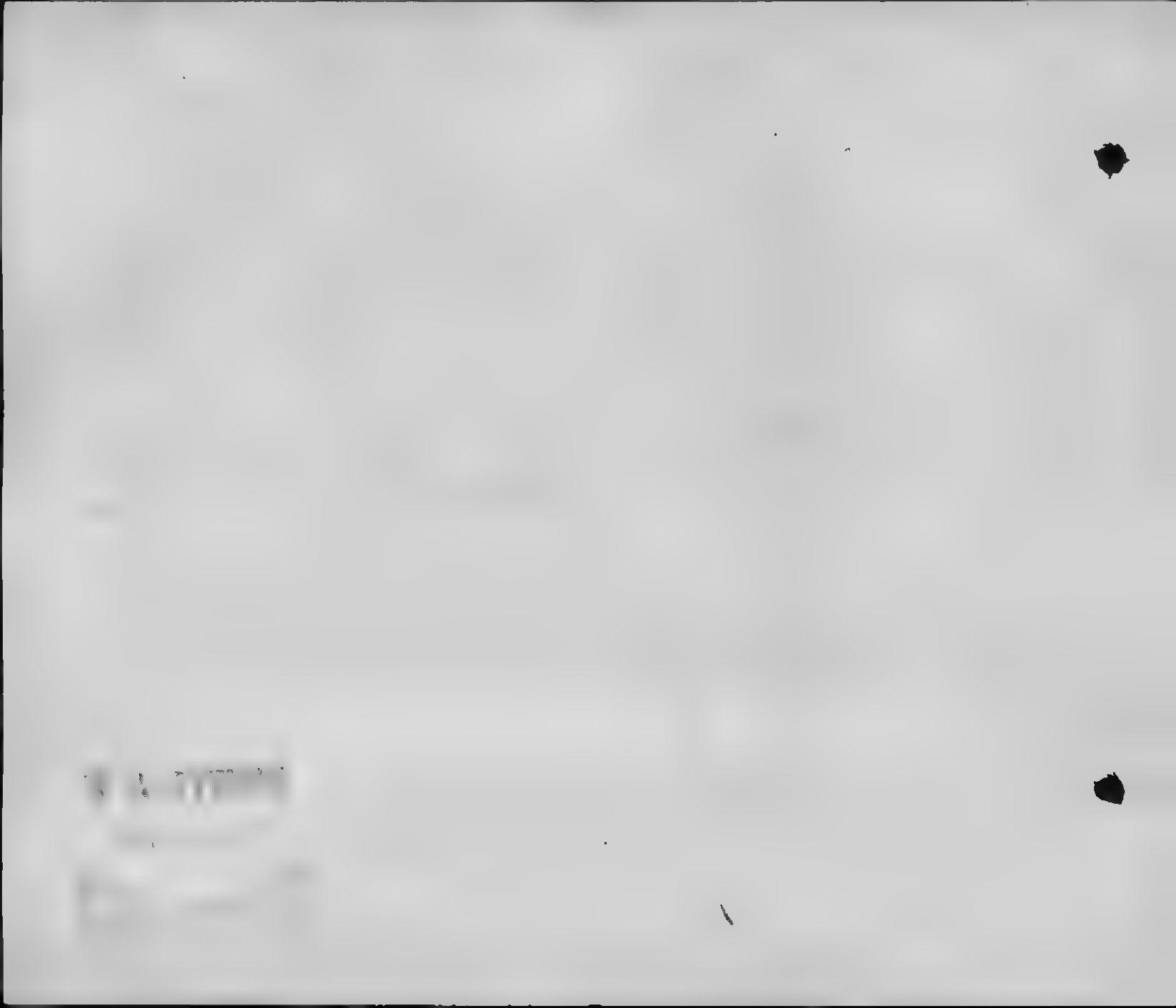
19a. DATE OF OPERATION: <u>7-23-55</u>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Highway</u>	21c. (City or town) (County) (State)	<u>R 196 W. Brittainville Monty MD</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Passenger in auto accident</u>		

22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .	
SIGNATURE <u>Frank J. Byers</u>	DATE SIGNED <u>7-19-55</u>
CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	

23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>7-23-55</u>	NAME OF CEMETERY OR CREMATORY <u>Coleville Mt.</u>	LOCATION (City, town, or county) (State) <u>Good Hope</u>
DATE REC'D BY LOCAL REG. <u>7-23-55</u>	REGISTRAR'S SIGNATURE <u>Charles J. ...</u>	24. FUNERAL DIRECTOR <u>Robert A. ...</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



6865

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Maryland	COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10325 Summit Avenue		STREET ADDRESS (If rural give location) 10325 Summit Avenue	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
George JOHNSON		July 9 19 55	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH.
Male	White	Married	Feb. 21, 1876
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter		10B. KIND OF BUSINESS OR INDUSTRY: Self-employed	9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 79 yrs. 4 18
11. BIRTHPLACE (State or foreign country): Buck Lodge, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Thomas Johnson		14. MOTHER'S MAIDEN NAME: Katherine Stewart	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-12-7898	
17. INFORMANT & ADDRESS: Mrs. Alta Johnson-Same Item #2			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE 177X		36 hours	
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) Acute myocardial failure			
DUE TO			
(B) Hypertensive heart disease		10 years?	
DUE TO			
(C) Carcinoma of prostate		3 years	
DUE TO			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Dec. 19, 1954 to July 9, 19 55 that I last saw the deceased alive on July 9, 19 55 , and that death occurred at 8:00 P. M. from the causes and on the date stated above.			
SIGNATURE Thomas G. Henderson		ADDRESS M. D. 3935 Balto. St. Kens. Md.	
DATE SIGNED 7/9/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7/12/1955	
NAME OF CEMETERY OR CREMATORY St. John's		LOCATION (City, town, or county) (State) Forest Glen, Montg. Md.	
DATE REC'D BY LOCAL REGISTRAR 7-12-55		REGISTRAR'S SIGNATURE Bessie M. Thompson	
FUNERAL DIRECTOR W. D. Humphrey		ADDRESS Bethesda, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. J. A. J. J.

Figure 1



1555

1987

6866

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE --		COUNTY --	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>Bethesda</u>		<u>235 days</u>		<u>Washington, D. C.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u> <u>Natl. Institutes of Health</u>				STREET ADDRESS (If rural give location) <u>1724 - 17th St. N.W.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Jan</u> <u>Karszo-Siedlewski</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>July</u> <u>8</u> <u>1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>December 1, 1891</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Translator</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Federal Government</u>		11. BIRTHPLACE (State or foreign country): <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Wlodyslaw Karszo-Siedlewski</u>				14. MOTHER'S MAIDEN NAME: <u>Aniela Gradzinow</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Not stated</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>205X</u> <u>Mycosis fungoides involving skin, lymph</u>							
ANTECEDENT CAUSE (B) <u>nodes, liver and lungs</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 15, 1954, to July 8, 1955, that I last saw the deceased alive on July 8, 1955, and that death occurred at 8:30AM, from the causes and on the date stated above.							
SIGNATURE <u>Eugene J. Van Scott</u>		ADDRESS <u>The Clinical Center</u> <u>M.D. Natl. Institutes of Health</u>		DATE SIGNED <u>July 8, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>July 11 - 1955</u>		DATE THEREOF		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		LOCATION (City, town, or county) (State) <u>Montgomery MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/9/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Martin W. Hyman</u>		ADDRESS <u>1300 N. ST.</u> <u>WASHINGTON, D.C.</u>	

PLEASE TYPE IN PLAIN, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100-100000

100

6867

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Montgomery</u>		MARYLAND	STATE <u>Maryland</u> COUNTY <u>Montgomery</u>		
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural give location) <u>5520 Johnson Avenue</u>			
3. NAME OF DECEASED: (First) <u>EDWARD</u> (Middle) <u>F.</u> (Last) <u>KEATING</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>July 29 19 55</u>		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Aug. 11, 1878</u>		9. AGE last birthday: <u>76</u> yrs. <u>11</u> Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Property guard</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>	
13. FATHER'S NAME: <u>Edward T. Keating</u>			14. MOTHER'S MAIDEN NAME: <u>Hanora Lonergan</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Mrs. Thomas Quigley</u> <u>Sister- 5520 Johnson Ave. Bethesda Md.</u>	
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE <u>453.1</u> (A) <u>Pneumonia</u>					<u>2 days</u>
ANTECEDENT CAUSE (B) <u>Coronary heart disease</u>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>55</u> , to <u>July 29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 29</u> , 19 <u>55</u> , and that death occurred at <u>8:45 P</u> M, from the causes and on the date stated above.					
SIGNATURE <u>Dr. Joseph Henrich</u>		ADDRESS <u>M. D. 6450 Wisconsin Ave. Bethesda Md.</u>		DATE SIGNED <u>7/29/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial-Transit</u>		DATE THEREOF <u>8-3-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cath Cem.</u> LOCATION (City, town, or county) (State) <u>Philadelphia, Pennsylvania</u>	
DATE REC'D BY LOCAL REGISTRAR <u>8/1/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



06853

Reg. Dist.

No. 214

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montg</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Montg.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Silver Spring</u>		LENGTH OF STAY (In this place) <u>7 mo</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>602 East Ave</u>				STREET ADDRESS (If rural, give location) <u>602 East Ave</u>			
3. NAME OF DECEASED: (First) <u>Zacharias</u> (Middle) <u>Kepalos</u> (Last) <u>Kepalos</u>				4. DATE OF DEATH (Month) <u>7</u> (Day) <u>-18</u> (Year) <u>1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>11-25-12</u>	
9. AGE last birthday: <u>42</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country): <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James Kepalos</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Pappas</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Angela Kepalos (Wife)</u> <u>Same as Deceased</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Cornary occlusion</u>						DUE TO	
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last</u>						DUE TO	
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. B. 202 Hart</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-18-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>7-22-55</u>		NAME OF CEMETERY OR CREMATORY <u>Arl. Nat. Cemetery</u>		LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
DATE REC'D BY LOCAL REG. <u>7-19-55</u>		REGISTRAR'S SIGNATURE <u>Frances Potter</u>		24. FUNERAL DIRECTOR <u>The S. N. Hines Co. 2901-14th St N.W. Washington 9 D.C.</u>			

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



6781

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>DC</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Takoma Park</u>	<u>3 days</u>	OR TOWN <u>Washington</u>	<u>47X-3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>Washington San. Hosp.</u>		<u>7049 31st St.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Catharine Elizabeth Keller</u>		OF DEATH <u>July 28 1955</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Cauc</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH: <u>Nov. 6, 1881</u>
9. AGE last birthday <u>73</u> yrs.		10. MONTHS <u>7</u> DAYS <u>28</u> HOURS <u>19</u> MIN.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life)		11. BIRTHPLACE (State or foreign country):	
<u>Housewife</u>		<u>Own home</u>	
13. FATHER'S NAME: <u>John T. Acker</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Neff</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hosp. Records</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
541.1 IMMEDIATE CAUSE		<u>12 hrs.</u>	
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
(A) <u>Peritonitis</u>			
(B) <u>Perforated duodenal ulcer</u>			
(C) <u>Rheumatoid arthritis</u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic pulmonary edema</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1952 to 7/28, 1955</u> , that I last saw the deceased alive on <u>7/28, 1955</u> , and that death occurred at <u>1225 P.M.</u> from the causes and on the date stated above.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 29, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		LOCATION (City, town, or county) (State) <u>Bladensburg Rd. Pr. Geob. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>July 28 1955</u>		REGISTRAR'S SIGNATURE <u>J. Wilson Dodd</u>	
FEDERAL DIRECTOR'S SIGNATURE <u>James D. Hall</u>		ADDRESS <u>254 CARROLL ST. N.W. Federal Park, D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

01-10-10

ALB 9

11-11-11

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural to Damascus Md</u>	STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural to Damascus Md</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)		
3. NAME OF DECEASED: (First) <u>KATHIE</u> (Middle) <u>KATHERINE</u> (Last) <u>KIDWILL</u>		4. DATE OF DEATH: (Month) <u>July</u> (Day) <u>18</u> (Year) <u>1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>July 9, 1869</u>
9. AGE last birthday: <u>86</u> yrs.		10. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country): <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>English</u>	
13. FATHER'S NAME: <u>John Hart</u>		14. MOTHER'S MAIDEN NAME: <u>Corn Barmes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>—</u>	
17. INFORMANT & ADDRESS: <u>Ernest Kidwell, Damascus, Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			Interval Between Onset And Death <u>10 years</u>
Immediate cause (a) <u>Arteriosclerotic cardiovascular disease</u>			
Antecedent causes (s) (b) <u>—</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>—</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: <u>—</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) <u>—</u> PLACE (Home, farm, factory, street, office bldg., etc.) <u>—</u> (CITY OR TOWN) <u>—</u> (COUNTY) <u>—</u> (STATE) <u>—</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u> m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	
HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>April 25, 1955</u> , to <u>July 18, 1955</u> , that I last saw the deceased alive on <u>July 12, 1955</u> , and that death occurred at <u>4:00 a.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>James B. Kern M.D.</u>		ADDRESS <u>Damascus Md.</u> DATE SIGNED <u>July 18, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> DATE THEREOF <u>July 20, 1955</u> NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u> LOCATION (City, town, or county) (State) <u>Cockeysville Md.</u>			
DATE RECD BY LOCAL REGISTRAR <u>July 19/55</u> REGISTRAR'S SIGNATURE <u>Della W. Burdette</u>		24. FUNERAL DIRECTOR <u>Ref. W. Barber</u> ADDRESS <u>1219</u>	

MARGIN RESERVED FOR BLINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6793

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH. <u>Rockville</u>				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		LENGTH OF STAY (in this place) <u>30 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		<u>26</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>212 Horners Lane</u>			
3. NAME OF DECEASED: (First) <u>John</u> (Middle) <u>Robert</u> (Last) <u>Kinder</u>		4. DATE OF DEATH: (Month) <u>July</u> (Day) <u>26</u> (Year) <u>1955</u>					
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>5/1/89</u>	9. AGE last birthday: <u>56</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Carpen Kelper Wash. Term. Co.</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME: <u>Harvey Brooks Kinder</u>				14. MOTHER'S M maiden NAME: <u>Margaret Ellen Thompson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS: <u>Vibla Kinder, (Wife) 212 Horners Lane, Rockville</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Bronchogenic Carcinoma</u>						<u>2 yrs 9 mos</u>	
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
(C) DUE TO							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>11/18/52</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Bronchogenic Carcinoma</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 11, 1955</u> to <u>July 26, 1955</u> ; that I last saw the deceased alive on <u>July 26, 1955</u> , and that death occurred at <u>10:35 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Dr. Bouditch Hunter</u>				ADDRESS <u>M.D. 509 W. Mill Rd. Rockville</u>		DATE SIGNED <u>7/27/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-29-55</u>		NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/27/55</u>		REGISTRAR'S SIGNATURE <u>Lamell H. Hagler</u>		FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06857
6870 CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton City</u> TOWN <u>Wheaton City</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4507 Adrian Street</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Wheaton City</u> STREET ADDRESS (If rural give location) <u>4507 Adrian Street</u>	
3. NAME OF DECEASED: (Type or Print) <u>Michael Joseph Kohan</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July 1 19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>Aug. 25, 1895</u>
9. AGE last birthday <u>59</u> yrs		10. AGE last birthday IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>File Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Westing House</u>	
11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Joseph Kohan</u>		14. MOTHER'S MAIDEN NAME: <u>Julia Havacs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>1507 Adrian Street</u>	
17. INFORMANT & ADDRESS: <u>William Kohan - Wheaton City, Md.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
150X IMMEDIATE CAUSE (A) <u>Cancer of the esophagus</u> DUE TO ANTECEDENT CAUSE (B) <u>metastatic cancer</u> (C) <u></u> DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		3 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>Apr. 19-55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Inoperable cancer of the esophagus, metastatic in the lung</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-17 April, 1955</u> , to <u>1-17 July, 1955</u> , that I last saw the deceased alive on <u>30-17 June, 1955</u> , and that death occurred at <u>2-50 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>G. H. Rauber, M.D.</u>		DATE SIGNED <u>July 1-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 5-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		LOCATION (City, town, or county) (State) <u>Prince George Co. Md.</u>	
24. FUNERAL DIRECTOR <u>W. W. Chambers Co.-Riverdale, Md.</u>		ADDRESS	

U. S. A.

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6871

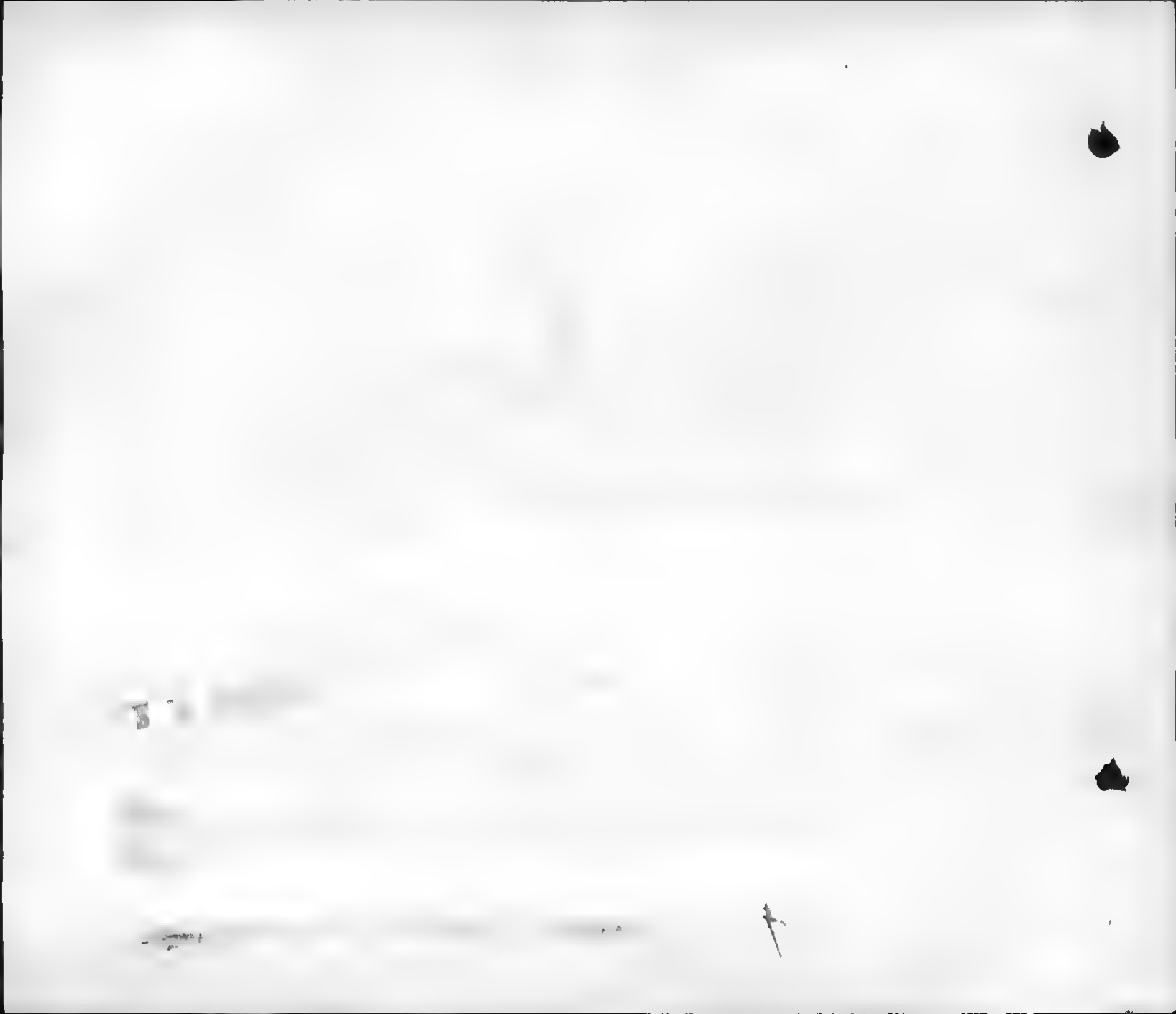
Item 14, Film 14-5 9-3-55 et

CERTIFICATE OF DEATH

Reg. Dist. No. 217

06858

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Olney</u>		<u>29 days</u>		TOWN <u>Brookeville</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>The Montgomery County General Hospital, Inc.</u>				<u>/</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First)		(Middle)		(Last)			
(Type or Print)		<u>William</u>		<u>Lawrence</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>male</u>		<u>colored</u>		<u>widowed</u>		<u>9/30/84</u>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS			
<u>70</u> yrs.		Months		Days		Hours	
						Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:			
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
<u>Maryland</u>				<u>U.S.A.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Lawrence</u>				<u>Mary Greenwell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS:							
<u>Hospital Records</u>							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE						<u>1446001</u>	
(A) <u>Apoplexy, Thrombosis</u>							
DUE TO							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B)							
DUE TO							
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
20. AUTOPSY?							
YES <input type="checkbox"/>				NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr. 1955</u> , to <u>July 1955</u> , that I last saw the deceased alive on <u>July 3, 1955</u> , and that death occurred at <u>2:10 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Dr. Bougart</u>		<u>Smiley, Sping, Md</u>		<u>9/4/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town or county) (State)	
<u>Burial</u>		<u>7-7-55</u>		<u>Valley Lee</u>		<u>St. Mary's County, Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7-7-55</u>		<u>Gertrude B. Towley</u>		<u>Robert L. Snowden</u>		<u>Brookeville, Md</u>	



6872

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> TOWN <u>Rural</u> LENGTH OF STAY (in this place) <u>3 hr. 8 min</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STATE <u>District of Columbia</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> OR TOWN <u>47 X-3</u> STREET ADDRESS (If rural give location) <u>1738 Corcoran Street, N.W.</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Ba by</u> <u>Boy</u> <u>LETHRIDGE</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>July</u> <u>13</u> <u>19 55</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Negroid</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>7-13-55</u>	
9. AGE last birthday <u>3</u> yrs		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>8</u>		11. IF UNDER 24 HRS Hours <u>3</u> Min. <u>8</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11 BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME: <u>William LETHRIDGE</u>				14. MOTHER'S MAIDEN NAME: <u>Colleen Delores SPICER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No. <u>None</u>			
17. INFORMANT & ADDRESS: <u>Mother Colleen D. LETHRIDGE</u> <u>Same as above</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Immaturity</u>						<u>3 hr. 8 min</u>	
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>7-14-55</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>13 July, 1955</u> , to <u>13 July, 19 55</u> , that I last saw the deceased alive on <u>13 July, 1955</u> , and that death occurred at <u>6:50 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>R. L. S. BAIRD LTJG, MC, USN</u>				ADDRESS <u>U. S. Naval Hospital, NNMC, Bethesda, Maryland</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>Burial</u>		DATE THEREOF <u>19 July 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Montgomery Co, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-14-55</u>		REGISTRAR'S SIGNATURE <u>Harry E. Carrelly</u>		24. FUNERAL DIRECTOR <u>Bell Brothers Funeral Home</u>		ADDRESS <u>621 Florida Ave., Washington, D.C.</u>	

MARGIN RESERVED FOR BINDING

VS. A15-10-53

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6873

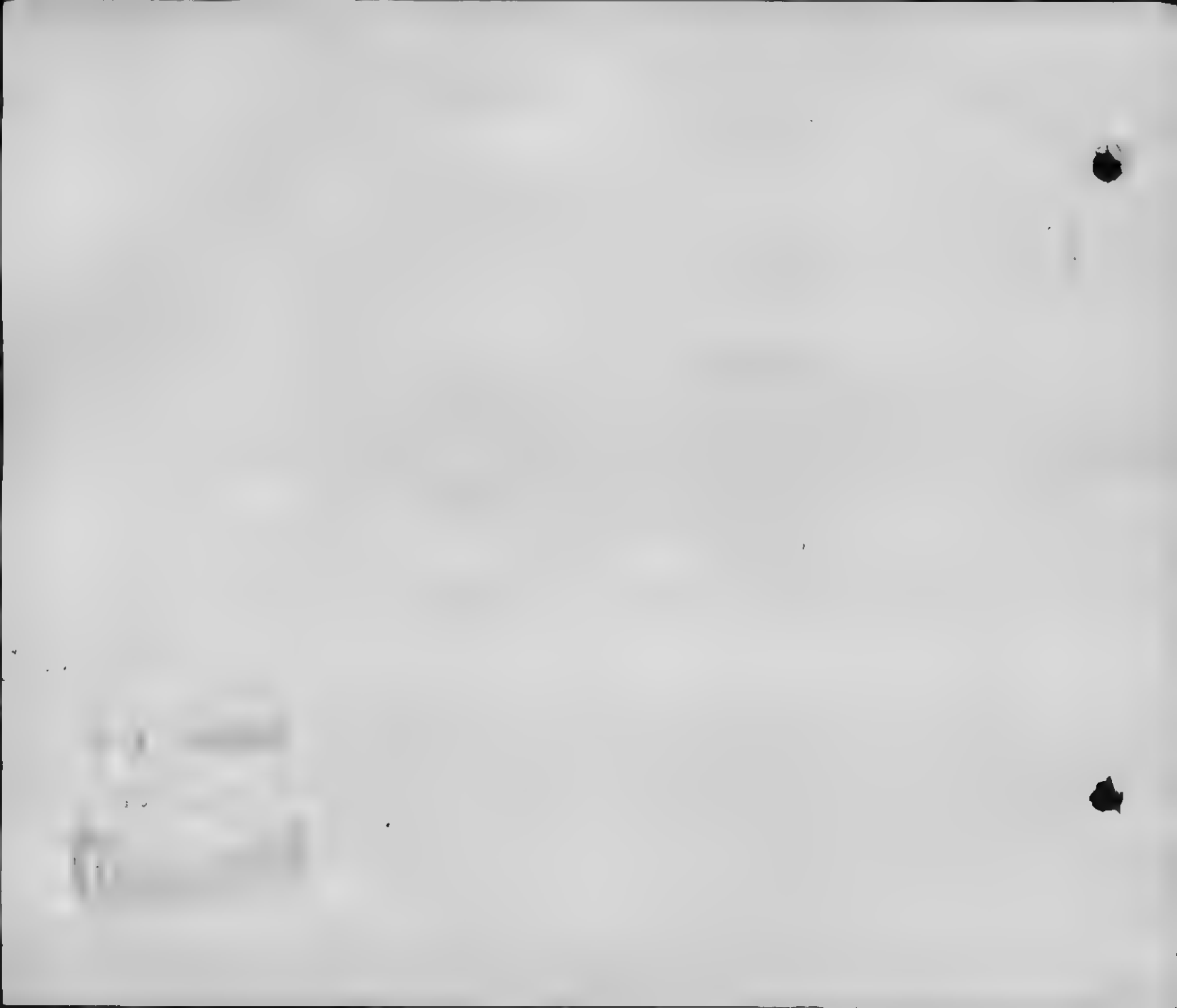
06860
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Mont.</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
<u>X TOWN Bethesda</u>		<u>10 hours</u>		<u>Silver Spring</u>			
HOSPITAL, OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
<u>Suburban</u>				<u>11708 Newport Mill Rd.</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First)		(Middle)		(Last)		(Month) (Day) (Year)	
<u>Irene</u>		<u>Kempie</u>		<u>Logan</u>		<u>July 6 19 55</u>	
(Type or Print)							
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED.	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	(Specify): <u>Widowed</u>	<u>Sept. 1, 1881</u>	<u>73</u> yrs	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>Tennessee</u>		<u>U.S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
						<u>Daughter, Mary Minogue - above</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Congestive Heart failure</u>							
DUE TO							
Antecedent cause(s) (b) <u>Generalized arteriosclerosis</u>							
DUE TO							
Diseases or conditions, if any, giving rise to the above cause (c) <u>Bronchial pneumonia</u>							
stating underlying cause last <u>Arterial atherosclerosis</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.)		21c. (City or town) (County) (State)			
		<u>Home</u>		<u>Potomac Montg Md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>July 2, 1955 P.M.</u>				<u>Fell on floor of her room.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE				M. D.			
<u>Frank G. Brockett</u>				<u>7-7-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>8 July 55</u>		<u>Cedar Hill Cemetery</u>		<u>Montg Md.</u>			
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		3821-14th St NW Wash, D.C.	
<u>7/7/55</u>		<u>Theresa M. Thompson</u>		<u>Thomas J. Collins</u>			



6873
CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md</u>	LENGTH OF STAY (in this place) <u>10 years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md</u>	OR TOWN <u>Silver Spring, Md</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1114 Woodside Parkway Silver Spring, Md</u>		STREET ADDRESS (If rural give location) <u>1114 Woodside Parkway Silver Spring, Md</u>	
3. NAME OF DECEASED (Type or Print) <u>First: Lawrence Bertrand Maloney</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>July 10 1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH: <u>March 28, 1903</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Owner</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Hardware</u>	9. AGE last birthday <u>52</u> yrs
11. BIRTHPLACE (State or foreign country): <u>Dayton, Md</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Thomas Maloney</u>		14. MOTHER'S MAIDEN NAME: <u>Susan Hill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>012-07-2169</u>	
17. INFORMANT & ADDRESS: <u>Wife - 1114 Woodside Parkway</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Pulmonary edema</u>		<u>3 hrs.</u>	
ANTECEDENT CAUSE (S) (B) <u>lung abscess</u>		<u>3 weeks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Bronchogenic carcinoma</u>		<u>10 months</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>Oct 54</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Bronchogenic carcinoma</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Silver Spring, Md</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>July 10, 1955</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <u>While at work</u>			
22. I hereby certify that I attended the deceased from <u>April, 1955</u> , to <u>July 10, 1955</u> , that I last saw the deceased alive on <u>July 10, 1955</u> , and that death occurred at <u>6:05 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Ralph E. Teller MD</u>		ADDRESS <u>8641 Colverville Rd Silver Spring, Md</u>	
DATE SIGNED <u>July 10, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>7-13-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Washington, D.C.</u>		LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>July 14, 1955</u>		REGISTRAR'S SIGNATURE <u>Frances Teller</u>	
24. FUNERAL DIRECTOR <u>James E. Teller</u>		ADDRESS <u>Washington, D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



6875

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> TOWN <u>Bethesda</u>	MARYLAND LENGTH OF STAY (in this place) <u>26 days</u>	STATE <u>Virginia</u> COUNTY <u>Alexandria</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Alexandria</u>	<u>x 3</u>
HOSPITAL OR INSTITUTE OR STREET ADDRESS <u>50 The Clinical Center</u> <u>National Institutes of Health</u>		STREET ADDRESS (If rural give location) <u>1317 Abingdon Drive</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>David</u> <u>Morgan</u> <u>Matthews</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July</u> <u>23</u> <u>1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>September 28, 1904</u>
9. AGE last birthday <u>50</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>SUPERVISOR, U.S. Govt</u>	
11. BIRTHPLACE (State or foreign country): <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>David Matthews</u>		14. MOTHER'S MAIDEN NAME: <u>Delia Friel</u>	
15. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>not available</u>	
17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>527.1</u>			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>BILATERAL TENSION PNEUMOTHORAX</u>		<u>10/23/55</u>	
DUE TO			
(B) <u>PULMONARY EMPHYSEMA</u>		<u>15/23/55</u>	
DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
<u>Chronic Cor PULMONALL</u>		<u>2/27/55</u>	
19A. DATE OF OPERATION: <u>2</u>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
	<u>at work</u>	<u>The Clinical Center</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>27 June, 1955</u> , to <u>23 July, 1955</u> , that I last saw the deceased alive on <u>23 July, 1955</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Eugene Braun</u>		DATE SIGNED <u>The Clinical Center</u> <u>M.D. National Institutes of Health</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>7-25-55</u>	NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>	LOCATION (City, town, or county) (State) <u>CLEVELAND, OHIO</u>
DATE REC'D BY LOCAL REGISTRAR <u>7/28/55</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR <u>S. H. Jones Co., Washington DC</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED V. S.

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U.S. DEPT. OF JUSTICE

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06863

6873 CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>Olney</u>		<u>16 days</u>		TOWN <u>Sandy Spring</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<u>Montgomery County General Hospital, Inc</u>		STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Elizabeth Olivia Matthews</u>				<u>July 3 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
<u>Female</u>	<u>Colored</u>	<u>Separated</u>	<u>2/23/12</u>	<u>43</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Domestic</u>				<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Walter Matthews</u>				<u>Bessie Newman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>Yes</u>				<u>Hospital Record</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
153X IMMEDIATE CAUSE (A) <u>Adenocarcinoma of colon</u>						<u>2 yrs</u>	
ANTECEDENT CAUSE (B): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<u>3/5/55</u>		<u>Adenoma-Carcinoma of the cecum</u>					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan.</u> , 19 <u>55</u> , to <u>July</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 2</u> , 19 <u>55</u> , and that death occurred at <u>4:40 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>L. B. Brumfield</u>		M. D. <u>Sandy Spring, Md.</u>		DATE SIGNED <u>7/3/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-6-55</u>		<u>Ash Memorial</u>		<u>Sandy Spring, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7-8-55</u>		<u>Arthur B. Lawrence</u>		<u>Robert L. Lawrence</u>		<u>Rockville, Md.</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6877 CERTIFICATE OF DEATH

06864
216

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED.			
COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Chevy Chase</u> TOWN <u>Chevy Chase</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9 Primrose St.</u>				STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Chevy Chase</u> TOWN <u>Chevy Chase</u> STREET ADDRESS (If rural give location) <u>9 Primrose St.</u>			
3. NAME OF DECEASED: (Type or Print) <u>WILLIAM ANDREW LEARNS</u>			4. DATE OF DEATH: <u>July 5</u> 19 <u>55</u>				
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>			
8. DATE OF BIRTH: <u>1-10-1870</u>		9. AGE last birthday: <u>85</u> yrs. <u>5</u> Months <u>20</u> Days <u>0</u> Hours <u>0</u> Min.		10. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): <u>Ret.</u>			
11. BIRTHPLACE (State or foreign country): <u>Phila., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>Robert Kirkpatrick Mearns</u>			
14. MOTHER'S MAIDEN NAME: <u>Martha D. Poole</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>			
17. INFORMANT & ADDRESS: <u>9 Primrose St.</u>		18. MEDICAL CERTIFICATION		Interval Between Onset And Death: <u>10 years</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>Cerebral arteriosclerosis</u> Immediate cause (a) <u>Cerebral arteriosclerosis</u> Antecedent cause(s) (b) <u>Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.</u> DUE TO (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>July 26, 1954</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 26, 1954</u> to <u>July 4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 2, 1955</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wm. M. D.</u>		DATE SIGNED <u>July 4 '55</u>		ADDRESS <u>1150 Conn. Av. N.W. Wash. D.C.</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>7-7-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>			
LOCATION (City, town, or county) (State) <u>Wash. DC</u>		DATE REC'D BY LOCAL REGISTRAR <u>7/6/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			
FUNERAL DIRECTOR'S SIGNATURE <u>Joseph L. Davis</u>		ADDRESS <u>1756 Pa. Ave. NW</u>					

PLEASE WRITE PLAINLY, WITH UNFADING INK. Apply every item of information carefully. The correct are is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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JUL 8 1955

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Reg. Dist. No. 215

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>District of Columbia</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
<u>Bethesda</u> Rural	<u>14 hr 46 min</u>	<u>Washington, D.C.</u> <u>47X 3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>U. S. Naval Hospital</u>		<u>3432 25th Street, S.E.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>Gregory Lee MILLER</u>		<u>July 31 19 55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>7-30-55</u>
9. AGE last birthday		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mjn.	
		<u>14 46</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>None</u>			
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Bethesda, Maryland</u>		<u>U.S.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Ivandale MILLER</u>		<u>Sue Yvonne ALLISON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>No</u>		<u>None</u>	
17. INFORMANT & ADDRESS:			
<u>Father Ivandale MILLER</u>		<u>Same as above</u>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE		<u>12 hr</u>	
ANTECEDENT CAUSE (S)		<u>Prematurity</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>30 July, 19 55</u> , to <u>31 July, 19 55</u> , that I last saw the deceased alive on <u>31 July, 19 55</u> and that death occurred at <u>12:45A</u> , from the causes and on the date stated above.			
SIGNATURE <u>Howard A. Pearson</u>		ADDRESS <u>H. A. PEARSON LTJG MC USN U.S. Naval Hospital, NMHC, Bethesda, Maryland</u>	
DATE SIGNED <u>4 Aug 1955</u>			
23. BURIAL CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>4 Aug 1955</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Arlington National Cemetery</u>		<u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>7-22-55</u>		<u>Wm. B. Parrelly</u>	
R4. FUNERAL DIRECTOR		ADDRESS	
<u>Funeral Home</u>		<u>7557 Wisconsin Avenue, Bethesda, Md.</u>	

BUNTAU V. S

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CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>D.C.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
X TOWN <u>Kensington</u>		<u>Since 9-10-54</u>		TOWN <u>Washington</u>		<u>47 X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		STREET ADDRESS		IF rural give location	
<u>91 Kensington Gardens 3000</u>		<u>McComas Ave</u>		<u>4700 Haverport St. N.W.</u>		<u>✓</u>	
3. NAME OF DECEASED: (Type or Print)		(First) <u>Olive</u>		(Middle) <u>B</u>		(Last) <u>Miller</u>	
5. SEX: <u>7</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>		8. DATE OF BIRTH: <u>Dec. 13-1881</u>	
9. AGE last birthday: <u>73</u> yrs.		10. DATE OF DEATH: <u>7-16</u> 19 <u>55</u>		11. BIRTHPLACE (State or foreign country): <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>CLERK</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>CHRISTOPHER W. CLASKETT</u>		14. MOTHER'S MAIDEN NAME: <u>EMMA RAYNOR</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>NO</u>		16. SOCIAL SECURITY NO.: <u>NONE</u>	
17. INFORMANT & ADDRESS: <u>REST HOME RECORDS</u>		18. MEDICAL CERTIFICATION		19. DATE OF OPERATION:		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		IMMEDIATE CAUSE		ANTECEDENT CAUSE (S)		DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	
442X		(A) <u>Constrictive Heart Failure</u>		(B) <u>Cardio-vascular-renal disease</u>		(C) <u>Parkinson's Disease</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept 4, 1954</u> , to <u>July 16 1955</u> , that I last saw the deceased alive on <u>July 13, 1955</u> , and that death occurred at <u>12:35 AM</u> , from the causes and on the date stated above.		SIGNATURE <u>Sidney Chausier</u>		DATE SIGNED <u>7/16/55</u>		M. D. <u>3921 Lussan St. N.W. Wash. D.C.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		7-18-55		Bluemont Cemetery		Wash. D.C.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
7-16-55		Bessie M. Thompson		Cherry Chase Funeral Home		5705 W. ...	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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100-100000

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6880

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06867

Item 9, Film 95 8-20-55 et

CERTIFICATE OF DEATH

Reg. Dist. No. 216

See: Item 17

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
X TOWN <u>Bethesda</u>		<u>Cherry Chase</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
<u>Suburban Hospital</u>		<u>8801 Montgomery Ave.</u>	
3. NAME OF DECEASED. (Type or Print)		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last)		OF DEATH: <u>July 18</u> <u>1955</u>	
<u>Michael J. Moses</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:
<u>M.</u>	<u>W.</u>	<u>Married</u>	<u>9/28/12</u>
9. AGE last birthday IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
<u>43</u> yrs		<u>42</u> yrs	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>Restaurant</u>			
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY:	
<u>Pennsylvania</u>		<u>U.S.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>John Moses</u>		<u>Rathade</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS:			
<u>Mrs. Mary Moses - Wife</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A)		<u>10 days</u>	
<u>443X</u>			
DUE TO			
ANTECEDENT CAUSE (B)		<u>8 years</u>	
DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		<u>2 years</u>	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
<u>Embolic stroke</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>7-17-55</u>		<u>A. popliteal embolism</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7-6-1955</u> , to <u>7:1 P.M.</u> , 19 <u>55</u> that I last saw the deceased alive on <u>7-18-1955</u> , and that death occurred at <u>12:15 P.M.</u> from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>James H. Leiper</u>		<u>7-18-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Rockville Ind. Park</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
<u>7-20-55</u>		<u>W.M. Chambers</u>	
REGISTRAR'S SIGNATURE		ADDRESS	
<u>Bessie M. Thompson</u>		<u>6-1400-Maple St.</u>	

RECEIVED

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Reg. Dist.

No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Montgomery	STATE	Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Chevy Chase	CITY (If outside corporate limits write RURAL and give nearest town)	Chevy Chase
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	7213 Oakridge Ave.	STREET ADDRESS	(If rural, give location) 7213 Oakridge Ave.,
3. NAME OF DECEASED:		4. DATE OF DEATH	
(Type or Print)	James Edward Mulligan	(Month)	(Day) (Year)
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
Male	White	Married	Sept. 7, 1901
9. AGE last birthday:	10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
53	Research Anal.	Augusta, Maine.	U.S.A.
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
James E. Mulligan		Elizabeth McCormick	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
No			
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
Mara Elizabeth Mulligan wife - Same as item #2.		19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:	
		Immediate cause (a) ... Coronary occlusion ... Antecedent cause(s) (b) ... Diseases or conditions, if any, giving rise to the above cause ... stating underlying cause last (c) ...	
20. AUTOPSY?		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
22. DATE OF OPERATION:		23. MAJOR FINDING OF OPERATION:	
24. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		25. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
26. TIME (Month) (Day) (Year) (Hour) OF INJURY		27. HOW DID INJURY OCCUR?	
M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
28. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED	
Transit Burial		M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> 7-23-55	
29. BURIAL, CREMATION, REMOVAL (Specify):		30. NAME OF CEMETERY OR CREMATORY	
Transit-burial		St. Patricks Cenetery	
DATE REC'D BY LOCAL REG.		31. FUNERAL DIRECTOR	
7-23-55		Robert A. Humphrey	
32. REGISTRAR'S SIGNATURE		33. ADDRESS	
Bessie M. Thompson		Bethesda, Md.	

MARGIN RESERVED FOR BINDING

VS. A15A-5-53

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED V. 3

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6882

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Maryland		COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda		LENGTH OF STAY (in this place) 23 days		CITY (If outside corporate limits, write RURAL and give nearest town) Silver Spring		56	
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Clinical Center National Institutes of Health				STREET ADDRESS (If rural give location) 10205 Proctor St.		1	
3. NAME OF DECEASED: (First) (Middle) (Last) Kinhead Worthington Munsch				4. DATE OF DEATH: (Month) (Day) (Year) July 13 1955			
5. SEX: F		6. COLOR OR RACE: W		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: 17 August 1895	
9. AGE last birthday: 59 yrs.		10. AGE last birthday: 59 yrs.		11. BIRTHPLACE (State or foreign country): U.S. Gov't. Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife - Clerk- Naval Ordnance				10B. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.			
13. FATHER'S NAME: Samuel Worthington				14. MOTHER'S MAIDEN NAME: Sallie Scott			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None given		17. INFORMANT & ADDRESS: The medical record, The Clinical Center	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 150X Confluent bronchopneumonia in a patient with recurrent carcinoma of the esophagus							
ANTECEDENT CAUSE (S) DUE TO Metastatic carcinoma in liver & multiple abdominal, thoracic & cervical lymph nodes							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: None				19B. MAJOR FINDINGS OF OPERATION: None			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) None		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 20, 19 55 to July 13, 19 55 that I last saw the deceased alive on July 13, 19 55 , and that death occurred at 8:00AM , from the causes and on the date stated above.							
SIGNATURE Bernard Robert Landau				ADDRESS M. D. The Clinical Center, NIH DATE SIGNED July 13, 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Trans. & Burial		DATE THEREOF 7/14/55		NAME OF CEMETERY OR CREMATORY Versailles Cemetery		LOCATION (City, town, or county) (State) Versailles, Woodford Co., Ky.	
DATE REC'D BY LOCAL REGISTRAR 7-13-55		REGISTRAR'S SIGNATURE Bessie M. Hampson		24. FUNERAL DIRECTOR Walter E. Humphrey		ADDRESS 8434 Ga. Ave. Silver Spring, Md.	

MARGIN RESERVED FOR BINDING

1927

1927

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06870

6883

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Virginia</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<u>Bethesda Rural</u>	<u>2 months</u>	<u>Bethesda</u>	<u>Rural</u> <u>Arlington</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>		STREET ADDRESS (If rural give location)	
		<u>1007 N. Jefferson St.</u>	<u>W. S. Matthews (see birth c.)</u>
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Virginia</u>	(Middle) <u>(N)</u>	(Last) <u>NEIL</u>	OF DEATH: <u>July 5 1955</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>4-28-55</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday (If under 1 year, give Months Days Hours Min.)
			<u>2 7</u>
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME: <u>John Spencer NEIL</u>		14. MOTHER'S MAIDEN NAME: <u>Anne C. WALSH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Father John S. NEIL</u>		18. MEDICAL CERTIFICATION	
<u>3910 Ave. W., Brooklyn, New York</u>		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		IMMEDIATE CAUSE (A) <u>Pneumonia, Terminal</u>	
ANTECEDENT CAUSE (B) <u>Multiple Congenital</u>		DUE TO <u>Abnormalities of Meningo-encephalocoele open & closed and microcephaly</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		2 Mo's	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		7 days	
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>28 April, 1955</u> , to <u>5 July, 1955</u> , that I last saw the deceased alive on <u>5 July 1955</u> and that death occurred at <u>7:05 A M.</u> from the causes and on the date stated above.			
SIGNATURE <u>W. S. Matthews, M.D.</u>		ADDRESS <u>W. S. MATTHEWS LCDR MC USN U. S. Naval Hospital NMHC Bethesda Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-9-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-5-55</u>		24. FUNERAL DIRECTOR ADDRESS <u>R. A. Pumphrey Funeral Home, 7557 Wisc., Avenue, Bethesda, Maryland</u>	

THOMAS A. S.

DEPT. OF AGRICULTURE
WASHINGTON, D. C.

6884
CERTIFICATE OF DEATH

Reg. Dist. No. 516

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chesley Chase</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural, give location) <u>5124 Bradley Blvd</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Mrs. Mary V. Newkirk</u>		OF DEATH: <u>July 7</u> 19 <u>55</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>10/19/76</u>
		9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Ohio</u>
			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME: <u>Tobias Hughes</u>		14. MOTHER'S MAIDEN NAME: <u>Florence Cannon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Francis M. Newkirk-Item # 2</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
4221 IMMEDIATE CAUSE (A) <u>intestinal hemorrhage</u>			
ANTECEDENT CAUSE (S) DUE TO <u>cause unknown</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>myocarditis, generalised</u>			
(C) <u>decalcification, extreme, of lumbar spine</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While at work Not while at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec.</u> , 19 <u>54</u> , to <u>7/7</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/7</u> , 19 <u>55</u> , and that death occurred at <u>12.50 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Dr. Philip Bloemina</u>		M.D. <u>5911 16th St. NW. Wash., D.C.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-9-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-12-55</u>		REGISTRAR'S SIGNATURE <u>Beasie M. Thompson</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06872

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> TOWN <u>Bethesda</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> OR TOWN <u>Bethesda</u> STREET ADDRESS (If rural give location) <u>5607 Lincoln Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>John William Norris</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>July 3 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Dec. 27, 1881</u>	9. AGE last birthday <u>73</u> yrs	IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u>	IF UNDER 24 HRS. Hours <u>6</u> Min. <u>6</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer Railroad</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Railroad</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME <u>Benjamin Franklin Norris</u>				14. MOTHER'S MAIDEN NAME: <u>Ann Louise Peters</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>6-11-11111</u>		17. INFORMANT & ADDRESS: <u>Mrs. Gertrude Funk - 5607 Lincoln</u> <u>Bethesda, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE							
ANTECEDENT CAUSE (B):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
(A) <u>Acute myocardial infarction</u>						<u>6 days</u>	
(B) <u>acute coronary thrombosis</u>						<u>4</u>	
(C) <u>anticoagulation</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-11-55</u> , 19 <u>55</u> , to <u>7-3-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7-1-55</u> , 19 <u>55</u> , and that death occurred at <u>1:00</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Beattie M. Thompson</u>		ADDRESS <u>M. D.</u>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-6-55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Hebron Cem.</u>		LOCATION (City, town, or county) (State) <u>Frederick Co. Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/4/55</u>		REGISTRAR'S SIGNATURE <u>Beattie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert R. Humphrey</u> ADDRESS <u>Bethesda, Md.</u>			

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06873

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>DC</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) <u>17 TOWN Takoma Park</u>	LENGTH OF STAY (in this place) <u>1 day</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	<u>17 x</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>75 Washington San. Hosp.</u>		STREET ADDRESS <u>6219 8th St. N.W.</u>	<u>✓</u>
3. NAME OF DECEASED: (Type or Print) First (Middle) (Last) <u>Walter Allan Osbourn</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July 4 1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE: <u>Cauc</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>4-14-1884</u>
9. AGE last birthday: <u>71</u> yrs		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired R.R. mail Service Emp.</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>James Osbourn</u>		14. MOTHER'S MAIDEN NAME: <u>Alice Link</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Hosp Records</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE		36 hrs.	
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		3 yrs.	
(A) <u>Acute myocardial infarction</u>			
(B) <u>Coronary atherosclerosis</u>			
(C) <u>Hypertensive cardiovascular disease</u>		3 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 3, 1955, to July 4, 1955, that I last saw the deceased alive on July 4, 1955, and that death occurred at 10 ³⁰ AM, from the causes and on the date stated above.			
SIGNATURE <u>Bennet A. Butler, Jr., M.D.</u>		ADDRESS <u>M.D. 9301 Colesville Rd., Silver Spring, Md.</u>	
DATE SIGNED <u>July 4, 1955</u>			
23. BURIAL, CREMATION, (Specify) <u>burial</u>		DATE THEREOF <u>7-6-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Shepherdstown Mts.</u>		LOCATION (City, town, or county) (State) <u>West Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>July 4-1955</u>		REGISTRAR'S SIGNATURE <u>John R. Dodd</u>	
FUNERAL DIRECTOR <u>Real Funeral Home</u>		ADDRESS <u>4812 1/2 Ave NW Wash</u>	

1941

1941

1941

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06874
6886
CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> CITY <u>Silver Spring</u> TOWN <u>Silver Spring</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>816 Gist Ave.</u>	MARYLAND LENGTH OF STAY (in this place) <u>19 years</u>	STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY <u>Silver Spring</u> TOWN <u>Silver Spring</u> STREET ADDRESS <u>816 Gist Ave.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>FRANK G. PALEOLOGOS</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July 22 - 19 55</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Nov. 28, 1891</u>
9. AGE last birthday: <u>63</u> yrs		10. BIRTHPLACE (State or foreign country): <u>Greece</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): <u>Resturant Owner</u>		12. CITIZEN OF WHAT COUNTRY? <u>None-exiled</u>	
13. FATHER'S NAME: <u>George Paleologos</u>		14. MOTHER'S MAIDEN NAME: <u>Chrysa Kahriss</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO <u>Yes-unavailable</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Despina Paleologos</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> IMMEDIATE CAUSE		<u>few minutes</u>	
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>myocardial Infarction</u>			
DUE TO			
(B) <u>Coronary thrombosis</u>		<u>31 months</u>	
DUE TO			
(C) <u>Coronary artery arteriosclerosis</u>		<u>31 months</u>	
DUE TO			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 29, 1951</u> , to <u>July 22, 1955</u> , that I last saw the deceased alive on <u>July 21</u> , 1955, and that death occurred at <u>2:45 P M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Clara H. Traim</u>		DATE SIGNED <u>July 23 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 25, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-25-55</u>		REGISTRAR'S SIGNATURE <u>Francis J. Teller</u>	
FUNERAL DIRECTOR <u>Walter C. Pumphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6783

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
17 TOWN <u>Takoma Park</u>		8 days		Silver Spring			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
76 <u>Washington Sanitarium & Hospital</u>				816 Gist Ave.			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Elias George Palogos</u>				DEATH: <u>7-8-1955</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE BIRTH: <u>3-15-95</u>	
9. AGE last birthday: <u>60</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>owner</u>		10B KIND OF BUSINESS OR INDUSTRY: <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country): <u>Greece</u>	
10A		10B		11		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME: <u>George Palogos (Paleologos)</u>				14. MOTHER'S MAIDEN NAME: <u>Chrissy Kachris</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16 SOCIAL SECURITY NO. <u>Yes (unavailable)</u>			
17. INFORMANT & ADDRESS: <u>Hospital Record</u>							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>420.1</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Massive infarct myocardium</u>						<u>8 days</u>	
(B) <u>Coronary artery thrombosis</u>						<u>8 days</u>	
(C) <u>Coronary arteriosclerosis</u>						<u>Unknown</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 30, 1955</u> , to <u>July 8, 1955</u> , that I last saw the deceased alive on <u>July 8, 1955</u> , and that death occurred at <u>2:43 PM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Carol H. Trauer</u>		<u>M. D. 8237 Georgia Ave Silver Spring Md</u>		<u>July 8 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/11/55</u>		<u>Glenwood Cemetery</u>		<u>Washington, D. C.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>July 10 1955</u>		<u>William D. Cold</u>		<u>Warner D. Lumphrey</u>		<u>8434 Ga. Ave. Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100-1000
100-1000
100-1000

6887

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR	
X TOWN <u>Olney</u>	<u>2 1/2</u> days	TOWN <u>Marriottsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery County General Hospital, Inc.</u>		STREET ADDRESS (If rural give location)	

3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Rebekah</u>	(Middle) <u>Elizabeth</u>	(Last) <u>Paul</u>	(Month) <u>July</u> (Day) <u>4</u> (Year) <u>19 55</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>12/16/73</u>
9. AGE last birthday: <u>81</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY: <u>None</u>	
13. BIRTHPLACE (State or foreign country): <u>Maryland</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

15. FATHER'S NAME: <u>Arthur McLean</u>		16. MOTHER'S MAIDEN NAME: <u>Ruth Hobbs</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		18. SOCIAL SECURITY NO. <u>unk</u>	
19. INFORMANT & ADDRESS: <u>Hospital Record</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE <u>420.0</u>		
(A) <u>Acute cardiac failure</u>	DUE TO	<u>17 hours</u>
ANTECEDENT CAUSE (S)		
(B) <u>Arteriosclerotic heart disease</u>	DUE TO	<u>5 years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Carcinoma uterus with metastasis to rectum causing acute intestinal obstruction.</u>		<u>1 week</u>

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 3, 19 55 to July 4, 19 55 that I last saw the deceased alive on July 3, 19 55, and that death occurred at 6:15 PM, from the causes and on the date stated above.

SIGNATURE <u>Charles S. Whitaker</u>	M. D. <u>Clarksville, Md</u>	DATE SIGNED <u>7/4/55</u>
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>Burial</u>	DATE THEREOF <u>7-7-55</u>	NAME OF CEMETERY OR CREMATORY <u>Mt View</u>
LOCATION (City, town, or county) (State) <u>Howard Co., Md.</u>	24. FUNERAL DIRECTOR	ADDRESS
DATE REC'D BY LOCAL REGISTRAR <u>July 5, 1955</u>	REGISTRAR'S SIGNATURE <u>Estelle B. Lawler</u>	ADDRESS <u>Arthur H. Haight - Glyndon, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



10-11-1911

10

6888

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>MONTGOMERY</u> MARYLAND			STATE <u>MARYLAND</u> COUNTY <u>MONTGOMERY</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>			CITY (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>		
X TOWN <u>BETHESDA</u> LENGTH OF STAY (in this place) <u>32 days</u>			OR TOWN <u>ROCKVILLE</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SUBURBAN HOSPITAL</u>			STREET ADDRESS (If rural give location) <u>806 GRANDIN AVENUE</u>		
3. NAME OF DECEASED: (First) <u>LAURA</u> (Middle) <u>E</u> (Last) <u>PETERS</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>JULY 15 1955</u>		
5. SEX. <u>FEMALE</u> 6. COLOR OR RACE: <u>WHITE</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>SINGLE</u>			8. DATE OF BIRTH: <u>DECEMBER 17, 1872</u> 9. AGE last birthday: <u>82 yrs</u> 6 Months 28 Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>GREENFIELD MARYLAND</u>		
11. BIRTHPLACE (State or foreign country): <u>GREENFIELD MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME: <u>JOHN WILLIAM PETERS</u>			14. MOTHER'S MAIDEN NAME: <u>SARAH ANN GEISLER</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>—</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>—</u>		
17. INFORMANT & ADDRESS: <u>IMOGENE NICHOLSON - 806 GRANDIN AVE.</u>					

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
9040 IMMEDIATE CAUSE (A) <u>Antero-Septic Heart Disease</u>	DUE TO	
ANTECEDENT CAUSE (B) <u>Fracture Left Femur</u>	DUE TO	<u>1 month</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(C)	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Melanterbia & Infection</u>

19A. DATE OF OPERATION: <u>6/15/55</u>	19B. MAJOR FINDINGS OF OPERATION: <u>Fracture Left Femur</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	21B. PLACE (Home, farm, factory, of injury street, office bldg., etc) <u>806 Grandin Ave. Mt. Md.</u>	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>806 Grandin Ave. Mt. Md.</u>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>6/12/55 9:30 A.M.</u>	21E. INJURY OCCURRED: While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <u>St. Fall - down</u>

22. I hereby certify that I attended the deceased from 6/13, 1955, to 7/15, 1955, that I last saw the deceased alive on 7/5, 1955, and that death occurred at 6 P.M., from the causes and on the date stated above.

SIGNATURE <u>Ernest B. Rothbaum</u>	DATE SIGNED <u>7/5/55</u>
ADDRESS <u>104 Cherry Church Ch. Md.</u>	M.D. <u>104 Cherry Church Ch. Md.</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>7-18-55</u>
NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u>	LOCATION (City, town, or county) (State) <u>Montgomery Co. Md.</u>

DATE REC'D BY LOCAL REGISTRAR <u>7-20-55</u>	REGISTRAR'S SIGNATURE <u>Bessie M. ...</u>	24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>	ADDRESS <u>Bethesda, Md.</u>
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MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W. J. Smith

W. J. Smith

6889

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	OR TOWN <u>3406 Cummings Lane</u>
X TOWN <u>Kensington</u>	<u>4 months</u>	STREET ADDRESS (If rural give location)	<u>Chevy Chase 15, Md</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS			
<u>90 Carroll Hall Sanatorium</u>	<u>10331 Carroll Place</u>		
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(Type or Print)	(First) (Middle) (Last)	OF DEATH:	
<u>Andretta</u>	<u>Wreath</u>	<u>July</u>	<u>22</u> <u>1955</u>
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>24 Nov 1870</u>
9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>84</u> yrs.	Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
<u>Housewife</u>		<u>New York, NY</u>	<u>USA</u>
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:		
<u>Andrew Wreath</u>	<u>Mary McGonigle</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:	
<u>No</u>		<u>Herbert L. Wreath</u> <u>3406 Cummings Lo, Chevy Chase 15, Md</u>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
332X IMMEDIATE CAUSE		4 days	
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		X years	
(A) <u>cerebral thrombosis</u>		X years	
(B) <u>cerebral arteriosclerosis</u>			
(C) <u>Generalized arterio sclerosis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<u>None</u>	
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?	
<u>None</u>	<u>None</u>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>20 July</u> 19 <u>55</u> , to <u>20 July</u> 19 <u>55</u> that I last saw the deceased alive on <u>20 July</u> 19 <u>55</u> , and that death occurred at <u>10:55</u> A.M. from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>David Luchs</u>		<u>22 July</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)
<u>Burial</u>	<u>7-25-55</u>	<u>KENSICO CEM.</u>	<u>WESTCHESTER CO. N.Y.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>7/28/55</u>	<u>Bernie Thompson</u>	<u>Joseph Hawler</u>	<u>504 11th St. N.Y.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Mr. Broschart Notified - has appeared
per Mr. Lucke 1:10^{PM} 7-23-55

6890

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH.				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>North Carolina</u>		COUNTY <u>Forsyth</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		LENGTH OF STAY (in this place) <u>2 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Winston Salem</u>		<u>NC</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>110 Schuyler Rd.</u>				STREET ADDRESS (If rural give location) <u>930 No. Hawthorne Rd.</u>			
3. NAME OF DECEASED: (First) <u>Mary</u> (Middle) <u>B</u> (Last) <u>Piper</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>July 17, 1955</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>		8. DATE OF BIRTH: <u>Jan 7, 1883</u>	
				9. AGE last birthday <u>72</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>-</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Albert M. Bounds</u>				14. MOTHER'S MAIDEN NAME: <u>Clara Cordelia Wilson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Alexander Piper, Winston Salem, NC</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE <u>334X</u>				<u>1 year</u>			
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Rheumatic heart disease</u>				<u>Years</u>			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 13, 1955</u> , to <u>July 17, 1955</u> , that I last saw the deceased alive on <u>June 21, 1955</u> , and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Severy Leventhal</u>		ADDRESS <u>Silver Spring, Md.</u>		DATE SIGNED <u>July 17, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 20, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-18-55</u>		REGISTRAR'S SIGNATURE <u>James G. Gatter</u>		24. FUNERAL DIRECTOR <u>Warner E. Pumphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2000

6784

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH

COUNTY Montgomery MARYLAND
 CITY (If outside corporate limits, write RURAL, and give nearest town)
 OR TOWN Takoma Park LENGTH OF STAY (in this place) 10 days
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Sanitarium & Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Missouri COUNTY St. Louis
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN Vinata Park
 STREET ADDRESS (If rural give location) 8211 Washington St.

3. NAME OF DECEASED:

(First) (Middle) (Last)
CHARLES EDWARD POLLAK

4. DATE (Month) (Day) (Year)
 OF DEATH: July 24 19 55

5. SEX:

male

6. COLOR OR RACE:

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

widowed

8. DATE OF BIRTH:

Dec. 1, 1869

9. AGE last birthday: (If under 1 year) (If under 24 hrs)
85 yrs | Months | Days | Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired):

Retired - Wholesale Milliner

10B. KIND OF BUSINESS OR INDUSTRY:

Louisiana, Mo.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME:

William Pollak

14. MOTHER'S MAIDEN NAME:

Mary Dvorak

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

Yes-unavailable

17. INFORMANT & ADDRESS:

Silver Spring, Md.
Edw. Chas. Pollak, 207 Lexington Drive,

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A) DUE TO

Congestive cardiac failure

INTERVAL BETWEEN ONSET AND DEATH

12 hrs

ANTECEDENT CAUSE (S)

(B) DUE TO

Severe posterior coronary thrombosis with infarction

10 days

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(C) DUE TO

General arterio-sclerotic card. - was dis

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) (County) (State)

INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

M.

21E. INJURY OCCURRED

While ☐ Not while ☐
at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1955, to July 24, 1955 that I last saw the deceased

alive on July 24, 1955, and that death occurred at 12:10 M. from the causes and on the date stated above.

SIGNATURE

E. Harmon

ADDRESS

3511 S. Main St. St. Louis, Mo.

DATE SIGNED

July 24, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

July 24, 1955

NAME OF CEMETERY OR CREMATOR

Bell Fountain Cemetery

LOCATION (City, town, or county) (State)

St. Louis, Missouri

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

J. H. H. H.

24. FUNERAL DIRECTOR

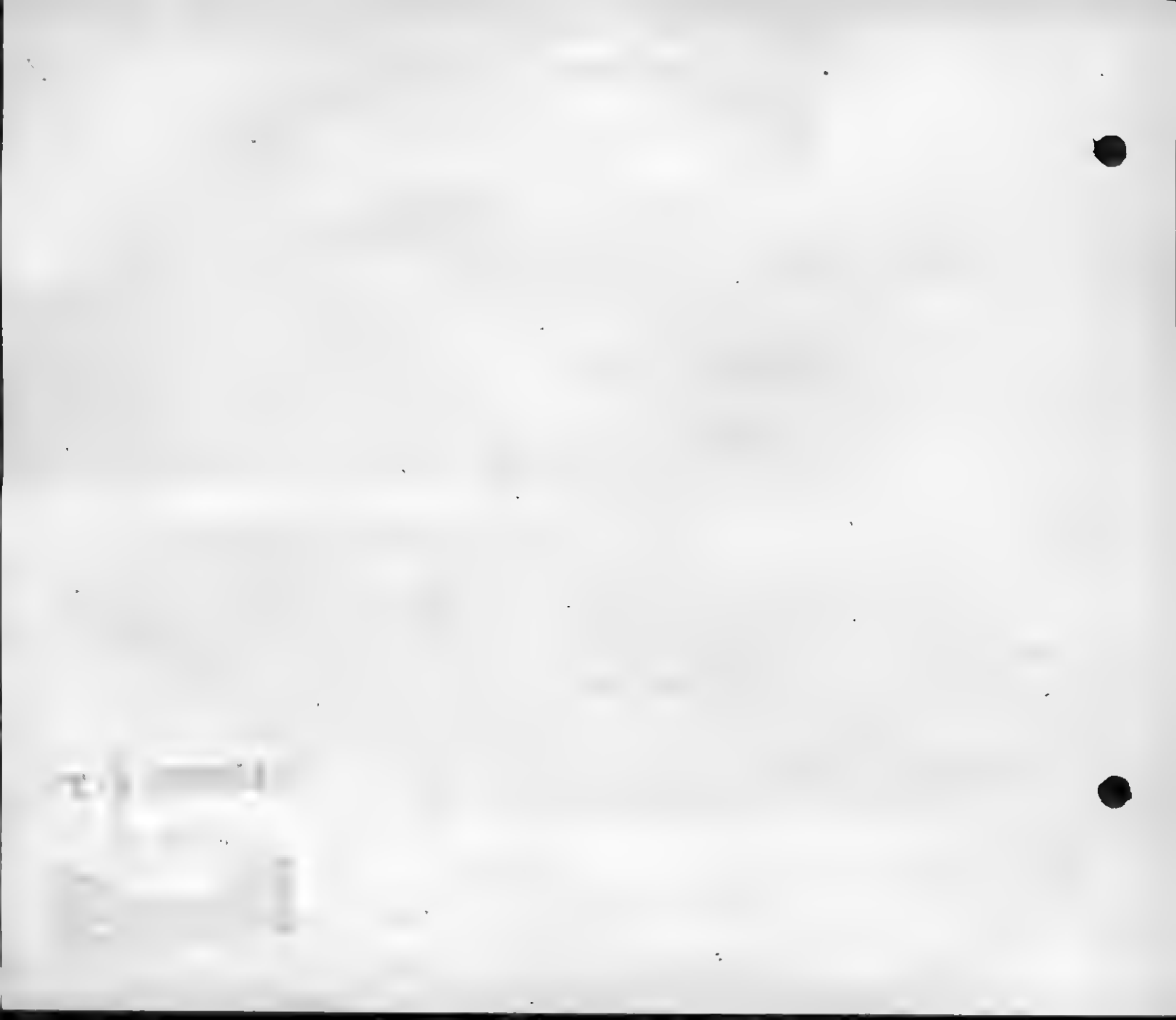
Dodd & Waver

ADDRESS

Silver Spring, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No. 217

6891

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Monig.</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>Montg.</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Spencer</u>		TOWN <u>Spencer, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
<u>Monig. Co. Gen. Hosp.</u>		<u>Spencer</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Boole</u>	(Middle) <u>Maggie</u>	(Last) <u>Amelin</u>	OF DEATH: <u>7</u> <u>24</u> 19 <u>55</u>
5. SEX: <u>f</u>	6. COLOR OR RACE: <u>w</u>	7. SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH: <u>6-30-70</u>
9. AGE last birthday: <u>85</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>same</u>	
11. BIRTHPLACE (State or foreign country): <u>Spencer, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Louis Duval</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Jane Spencer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS:	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE <u>422.2</u>		<u>6 hrs.</u>
ANTECEDENT CAUSE (S)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		<u>10 yrs.</u>
(A) <u>Apoplexy, etc.</u>		
DUE TO		
(B) <u>Chronic myocarditis</u>		
DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/3, 1955, to 7/24, 1955, that I last saw the deceased alive on 7/24, 1955, and that death occurred at M. from the causes and on the date stated above.

SIGNATURE <u>E. B. Broughton</u>	DATE SIGNED <u>7/28</u>
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23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>July 26-55</u>	<u>Union Cemetery</u>	<u>Spencer, Md.</u>

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>July 26-55</u>	<u>William B. Fowler</u>	<u>Robert Donaldson</u>	<u>Spencer, Md.</u>

MARGIN RESERVED FOR BINDING

BUENOS AIRES

AUG 2

100-100000

6892

CERTIFICATE OF DEATH

Reg. Dist. No. 217...

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Olney</u>		<u>2 days</u>		OR TOWN <u>Gaithersburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Montgomery County General Hospital, Inc</u>				<u>/</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Annie Virginia Pope</u>				<u>July 13 1955</u>			
5. SEX: <u>Female</u>				6. COLOR OR RACE: <u>White</u>			
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>				8. DATE OF BIRTH: <u>7/31/1873</u>			
9. AGE last birthday <u>81</u> yrs.				10. IF UNDER 1 YEAR: Months Days Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY:			
				11. BIRTHPLACE (State or foreign country): <u>Maryland</u>			
13. FATHER'S NAME: <u>Rufus Stevens</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Kenney</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT & ADDRESS: <u>Hospital Record</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Acute Coronary Occlusion</u>						<u>3 days</u>	
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
				21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 11, 1955</u> to <u>July 13, 1955</u> , that I last saw the deceased alive on <u>July 13, 1955</u> , and that death occurred at <u>4:12 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>John Schumacher</u>				DATE SIGNED <u>July 13, 1955</u>			
M. D. <u>Baltimore, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-15-55</u>		<u>Woodfield</u>		<u>Woodfield Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
<u>July 14, 1955</u>		<u>Gertrude B. Samler</u>		<u>W. Ernest C. Foster</u>		<u>Gaithersburg</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



6892

06883

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. *214*

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Montgomery</i>		MARYLAND		STATE <i>MD</i>		COUNTY <i>Montgomery</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <i>Silver Spring</i>		<i>4 yrs</i>		TOWN <i>Silver Spring</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>8902 Manchester Rd</i>				STREET ADDRESS (If rural, give location) <i>8902 Manchester Rd</i>			
3. NAME OF DECEASED: (First) <i>John</i> (Middle) <i>Peacock</i> (Last) <i>Potter</i>				4. DATE OF DEATH (Month) <i>7</i> (Day) <i>17</i> (Year) <i>1955</i>			
5. SEX: <i>Male</i>		6. COLOR OR RACE: <i>W</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>		8. DATE OF BIRTH: <i>Oct 22, 1922</i>	
9. AGE last birthday: <i>32</i> yrs.		10. BIRTHPLACE (State or foreign country): <i>Detroit, Michigan</i>		11. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
12. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Housewife</i>				13. KIND OF BUSINESS OR INDUSTRY: <i>Own home</i>			
14. FATHER'S NAME: <i>Marshall Peacock</i>				15. MOTHER'S MAIDEN NAME: <i>Rachel McLeod</i>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>No</i> (If Yes, give war or dates of service)				17. SOCIAL SECURITY No.: <i>Yes</i>		18. INFORMANT & ADDRESS: <i>W. Taylor Potter, 8902 Manchester Rd., SS</i>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<p>Immediate cause (a) <i>Barturate poisoning</i></p> <p>Antecedent cause(s) (b) <i>Was a mental case and had taken a number of powerful caps.</i></p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)</p>				<p><i>Found dead at home</i></p>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION: <i>7-18-55</i>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <i>Frank J. Broschard</i>		M. D. <i>Waxner E. Pumphrey</i>		DATE SIGNED <i>7-17-55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Cremation</i>		DATE THEREOF <i>July 18, 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Crematory</i>	
DATE REC'D BY LOCAL REG. <i>7-18-55</i>		REGISTRAR'S SIGNATURE <i>Frances Potter</i>		LOCATION (City, town, or county) (State) <i>Prince George's Co., Md.</i>	
		24. FUNERAL DIRECTOR		ADDRESS <i>Silver Spring, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06884

6894

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		X	
X TOWN <u>Bethesda</u>		<u>309 days</u>		TOWN <u>Kensington</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center National Institutes of Health</u>				STREET ADDRESS (If rural give location) <u>10310 Greenfield St.</u>			
3. NAME OF DECEASED: (First) <u>George</u>		(Middle) <u>A.</u>		(Last) <u>Powers</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>July 29, 1955</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>July 27, 1905</u>	
9. AGE last birthday: <u>50</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Music teacher</u>		11. BIRTHPLACE (State or foreign country): <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>George E. Powers</u>				14. MOTHER'S MAIDEN NAME: <u>Anna Macdonald</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>yes WW II</u>				16. SOCIAL SECURITY No. <u>031-12-4108</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
430.0 IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>							
ANTECEDENT CAUSE (B) <u>Subacute Bacteria Endocarditis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Carcinoma of the Stomach</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>12/6/54</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Inoperable Carcinoma of the Stomach</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>None</u>		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sep 23, 1954</u> , to <u>July 29, 1955</u> that I last saw the deceased alive on <u>July 29, 1955</u> , and that death occurred at <u>11:50 PM</u> , from the causes and on the date stated above.							
SIGNATURE: <u>John L. Tahay</u>		ADDRESS: <u>The Clinical Center</u>		M. D. Nat'l Inst. of Health		DATE SIGNED: <u>7/30/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF: <u>8-2-1955</u>		NAME OF CEMETERY OR CREMATORY: <u>Arlington Nat'l Cem.</u>		LOCATION (City, town, or county) (State): <u>Arlington Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>8/1/55</u>		REGISTRAR'S SIGNATURE: <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR: <u>Robert A. Humphrey</u>		ADDRESS: <u>Bethesda, Md.</u>	



6-15 1.000000

06885

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6785

CERTIFICATE OF DEATH

Reg. Dist. No. 213-

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
17 TOWN <u>Takoma Park</u>	<u>3 days</u>	TOWN <u>Takoma Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
<u>Washington Sanitary & Hospital</u>		<u>113 Elm Ave</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
(Type or Print) <u>JOHN JAMES RAINES</u>		DATE OF DEATH: <u>July 3 1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE. MARRIED. WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>8/25/1870</u>
		9. AGE last birthday: <u>83</u> yrs.	IF UNDER 1 YEAR: Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Virginia</u>
13. FATHER'S NAME: <u>M. (name unknown) Raines</u>		14. MOTHER'S MAIDEN NAME: <u>Josephine (last name unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Benjamin Raines 113 Elm Ave Takoma Park</u>	

15. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
491X IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>		<u>unknown</u>
ANTECEDENT CAUSE (B) <u>Cerebra</u>		<u>unknown</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>7/1</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------------------	----------------------------------	--

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <u>7/1</u> , 1955, to <u>7/3</u> , 1955, that I last saw the deceased alive on <u>7/2</u> , 1955, and that death occurred at <u>4.4 M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Benjamin Raines</u>		ADDRESS <u>M. D. 8901 University Lane S. S. Ind.</u>	DATE SIGNED <u>7/3/55</u>
23. BURIAL CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Removal</u>	<u>7-3-55</u>	<u>Washington D.C.</u>	<u>D.C.</u>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTER'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>July 2-1955</u>	<u>J. Wilson</u>	<u>Decker Funeral Home</u>	<u>4812 Pa. Ave NW Wash</u>

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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6895

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montg.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Kensington</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Kensington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10127 Cedar Lane</u>				STREET ADDRESS (If rural give location) <u>10127 Cedar Lane</u>			
3. NAME OF DECEASED: (First) <u>Anna</u> (Middle) <u>Rajacich</u> (Last) <u>Rajacich</u>				4. DATE OF DEATH: (Month) <u>July</u> (Day) <u>14</u> (Year) <u>1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>Apr. 5 1877</u>	
				9. AGE last birthday: <u>78</u> yrs. <u>3</u> Months <u>9</u> Days <u></u> Hours <u></u> Min.			
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Yugoslavia</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Michael Rae -son</u> <u>10127 Cedar Lane, Kensington, Md.</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>260X Immediate cause</u> (a) <u>Diabetic Coma</u> DUE TO Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						Interval Between Onset And Death <u>1 day</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Generalized Arteriosclerosis</u>							
19a. DATE OF OPERATION: <u>7/12/55</u>				19b. MAJOR FINDINGS OF OPERATION: <u>30 year</u>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/12/55</u> , to <u>7/14/55</u> , that I last saw the deceased alive on <u>7/14/55</u> , and that death occurred at <u>7:30 PM</u> from the causes and on the date stated above. SIGNATURE <u>James J. Curry M.D.</u> (Degree or title) ADDRESS <u>11301 Georgia Ave</u> DATE SIGNED <u>7/14/55</u>							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial - Transit</u>		<u>7-15-55</u>		<u>Calvary Cemetery</u>		<u>St. Louis Co. Minneapolis</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-15-55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

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6896

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Montg.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>TOWN Rural - Damascus</u> LENGTH OF STAY (in this place) <u>Years</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>TOWN Rural - Damascus</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. Mt. Airy</u>				STREET ADDRESS (If rural give location) <u>R.F.D. Mt. Airy</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Mamie Elizabeth Ridgley</u>			4. DATE OF DEATH: (Month) (Day) (Year) <u>July 5 19 55</u>				
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>June 3, 1884</u>		9. AGE last birthday: <u>71</u> yrs. Months Days Hours Min.		
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired <u>Housewife - Own Home</u>			10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Frederick Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>Benjamin Browning</u>				14. MOTHER'S MAIDEN NAME: <u>Lydia Lydard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>James D. Ridgley, Mt. Airy, Md.</u>			
18. MEDICAL CERTIFICATION							Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>156.1</u> Immediate cause (a) <u>Cancer of the liver</u> Antecedent cause(s) (b) <u>DUE TO</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>DUE TO</u>							<u>8 months</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>0</u>			19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 10, 1954</u> to <u>July 5, 1955</u> , that I last saw the deceased alive on <u>July 3, 1955</u> , and that death occurred at <u>12:50 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>James G. Kerr M.D.</u>				ADDRESS <u>Damascus, Md.</u>		DATE SIGNED <u>7/5/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 7, 1955</u>		<u>Damascus</u>		<u>Damascus, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>July 8, 1955</u>		<u>Della M. Burdette</u>		<u>Olin L. Molesworth, Damascus, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

ENCLOSURE

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6897
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06888

Reg. Dist.

No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
TOWN <u>Cherry Chase</u>		<u>1 yr</u>		TOWN <u>Cherry Chase</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8412 Farrell St</u>				STREET ADDRESS (If rural, give location) <u>8412 Farrell St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Max</u> <u>Ripplin</u>				<u>July</u> <u>27</u> <u>1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>3-31-12</u>	9. AGE last birthday: <u>43</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Store clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USC</u>	
13. FATHER'S NAME: <u>Abraham Ripplin</u>				14. MOTHER'S MAIDEN NAME: <u>Anna Deaton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Virginia Ripplin (Wife) Same as above</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a).....		DUE TO			
<u>Coronary occlusion</u>					
Antecedent cause(s) (b).....		DUE TO			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Frank J. Broschart</u>		M. D.		DATE SIGNED <u>7-27-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>7/28/55</u>		NAME OF CEMETERY OR CREMATORY <u>Travis Church</u>	
DATE REC'D BY LOCAL REG. <u>7-29-55</u>		REGISTRAR'S SIGNATURE <u>Frances Potter</u>		24. FUNERAL DIRECTOR ADDRESS <u>1018-9th St NW Wash, D.C.</u>	



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6898

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

COUNTY Montgomery

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

X TOWN BethesdaLENGTH OF STAY
(in this place)
14 hoursHOSPITAL OR
INSTITUTION OR74 STREET ADDRESS Suburban Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Montgomery

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN Silver Spring

STREET ADDRESS (If rural, give location)

ADDRESS 8417 Dixon Avenue3. NAME OF
DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

CATHERINE CARTER ROCHE4. DATE
OF
DEATH:

(Month)

(Day)

(Year)

JULY 21 1955

5. SEX:

F6. COLOR OR
RACE:W7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify): M

8. DATE OF BIRTH:

Nov. 20, 1908

9. AGE last birthday:

46 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired): Homemaker10b. KIND OF BUSINESS OR
INDUSTRY:
Own Home

11. BIRTHPLACE (State or foreign country):

New York12. CITIZEN OF WHAT
COUNTRY?U. S. A.

13. FATHER'S NAME:

Joseph J. Carter

14. MOTHER'S MAIDEN NAME:

Agnes Lyons15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.): No
(If Yes, give war or dates of
service)

16. SOCIAL SECURITY No.:

None

17. INFORMANT & ADDRESS:

Frank S. Roche, 8417 Dixon Ave., Silver SpringMd.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

433.1
Immediate cause

DUE TO

(a) Multiple Pulmonary Infarctions and FibrosisINTERVAL BETWEEN
ONSET AND DEATH3 days

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating underlying cause last

DUE TO

(b) Chronic Embolism, Recurrent8 years(c) Chronic auricular fibrillation8 years

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not
related to the disease or condition causing death.Chronic Cardiac Failure6-7 years

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Not while
M. work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 10, 1955, to July 21, 1955, that I last saw the deceased
alive on July 21, 1955, and that death occurred at 2:50 A.M., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITL.) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

7-22-55Beaue M. ThompsonWarner E. PumphreySilver Spring, Md.

MARGIN RESERVED FOR BINDING

U. S. DEPARTMENT OF AGRICULTURE

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111

6786

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>MONTG</u>	MARYLAND		STATE <u>MD</u>	COUNTY <u>MONTG</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>TAKOMA PARK</u> 11		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7314 WILLOW AVE</u>			STREET ADDRESS (If rural give location) <u>7314 WILLOW AVE.</u> 1		
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE (Month) (Day) (Year) OF DEATH		
<u>MARY OLIVIA RODGERS</u>			<u>July 8th 1955</u>		
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH: <u>JAN 23, 1881</u>		
			9. AGE last birthday <u>74</u> yrs. <u>74</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSEMAKER</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country): <u>PARIS, TEXAS</u>	
13. FATHER'S NAME: <u>TOM CRAIG</u>			14. MOTHER'S MAIDEN NAME: <u>CRAIG</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>—</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS: <u>MRS MARY ISABELLE ACREE TAK PA</u> <u>7314 WILLOW AVE</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>PULMONARY FAILURE</u>		<u>2 DAYS</u>
ANTECEDENT CAUSE (B) <u>METASTATIC CARCINOMA</u>		<u>1 YEAR</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>CARCINOMA OF COLON</u>		<u>1 1/2 YEARS</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>CARCINOMA OF COLON</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 3/24, 1955, to 7/8, 1955, that I last saw the deceased alive on 6/30, 1955, and that death occurred at 9 AM, from the causes and on the date stated above.

SIGNATURE James Coleman MD ADDRESS M. D. 113 CARROLL ST NW WASH. DC DATE SIGNED JULY 8, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>July 8, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	LOCATION (City, town, or county) (State) <u>Britland Park Co., Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>July 8, 1955</u>		REGISTRAR'S SIGNATURE <u>J. Wilson Rood</u>		24. FUNERAL DIRECTOR'S ADDRESS <u>254 Carroll St NW Takoma Park, MD</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BILLING

JUL

1944

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>6-25-55</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	TOWN <u>Bethesda</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>		STREET ADDRESS (If rural give location) <u>7900 Linbrook Drive</u>	
3. NAME OF DECEASED: (First) <u>John</u> (Middle) <u>Leal</u> (Last) <u>Rosander</u>		4. DATE OF DEATH: (Month) <u>July</u> (Day) <u>9</u> (Year) <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>April 20, 1892</u>
9. AGE last birthday <u>63</u> yrs. <u>2</u> months <u>19</u> days		10. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country): <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Unknown</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>A.C. Rosander, Son, 7900 Linbrook, Bethesda, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Respiratory Failure</u>			<u>6 hrs.</u>
ANTECEDENT CAUSE (B) <u>Heart Failure - A-V Block</u>			<u>2 weeks</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerosis and Enlarged Heart</u>			<u>2 yrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>7/10/55</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>6/26, 1955</u> to <u>7/9, 1955</u> , that I last saw the deceased alive on <u>7/8, 1955</u> , and that death occurred at <u>1:35 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Frank J. Jazay, M.D.</u>		DATE SIGNED <u>7/9/55</u>	
ADDRESS <u>5707 W. Chesapeake Ave. M.D. Chevy Chase, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial-transit</u>		24. FUNERAL DIRECTOR <u>Mason Co. Michigan</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-12-55</u>		REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>	
25. ADDRESS <u>Bethesda, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED BY THE

LIBRARY

1971

CERTIFICATE OF DEATH

Reg. Dist. No. 223

6787

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>TAKOMA PARK</u>	STATE <u>Dash DC</u> COUNTY <u>Washington</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Wash DC</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1111 Sun + 1st</u>	LENGTH OF STAY (in this place) <u>3 mos 8 da</u>	STREET ADDRESS (If rural give location) <u>3850 Tun run Rd</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
DAVID LEWIS SANDOE		DATE OF DEATH: 7 9 1955	
5. SEX: M	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH 2-8-61
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WASHINGTON POST		9. AGE last birthday: 94 yrs	
10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): PA.	
13. FATHER'S NAME Anthony Sandoe		12. CITIZEN OF WHAT COUNTRY? USA	
14. MOTHER'S MAIDEN NAME: Rebecca Cedar		17. INFORMANT & ADDRESS Mrs. Laura Sandoe Same.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service: no		16. SOCIAL SECURITY NO.	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
456X IMMEDIATE CAUSE (A) Hypertensive Paresis		3 days	
ANTECEDENT CAUSE (S) (B) Sanguine right leg		3 weeks	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) Endarteritis Obliterans		3 weeks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Myocarditis		1	
19A. DATE OF OPERATION: -		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory) OF INJURY street, office bldg., etc.	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4-25, 1955 to 7-3, 1955 that I last saw the deceased alive on 7-3, 1955, and that death occurred at 8:40 P.M. from the causes and on the date stated above.			
SIGNATURE <u>John L. Dr. Mayo</u>		DATE SIGNED <u>7-3-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		DATE THEREOF <u>7-7-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Lee Crematory</u>		LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>July 4-1955</u>		24. FUNERAL DIRECTOR <u>John W. Dadd</u>	
REGISTRAR'S SIGNATURE <u>John W. Dadd</u>		ADDRESS <u>844 W. 1st St. - Wash. D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3 4 100000

2 700

6900

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Montgomery	MARYLAND	STATE Md.	COUNTY Montg.
CITY (If outside corporate limits, write RURAL OR and give nearest town) Bethesda	LENGTH OF STAY (in this place) 119 days	CITY (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Clinical Center National Institutes of Health		STREET ADDRESS (If rural give location) 5318 Wakefield Road (Green Acres)	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) Lucy	(Middle) Glyde	(Last) Schack	OF DEATH: July 19, 1955
5. SEX: F	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 4 October 1906
		9. AGE last birthday: 48 yrs.	10. IF UNDER 1 YEAR: Months 9 Days 15 Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Virginia
13. FATHER'S NAME: (First Name unknown) Clyde		14. MOTHER'S MAIDEN NAME: Ewile Morris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No		17. INFORMANT & ADDRESS: The medical record, The Clinical Center	
18. SOCIAL SECURITY NO.: None			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Malignant Melanoma - multiple Metastases			
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: None		19B. MAJOR FINDINGS OF OPERATION: None	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc. INJURY OCCUR?	
		None	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from March 22, 1955 , to July 19, 1955 , that I last saw the deceased alive on July 19, 1955 , and that death occurred at 6:35A M. from the causes and on the date stated above.			
SIGNATURE Ross M. Miller		ADDRESS M.D. The Clinical Center, NIH DATE SIGNED July 19, 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 7-22-55	NAME OF CEMETERY OR CREMATORY Chatham Burial Park	LOCATION (City, town, or county) (State) Chatham, Virginia
DATE REC'D BY LOCAL REGISTRAR 7-20-55	REGISTRAR'S SIGNATURE Bessie M. Thompson	FUNERAL DIRECTOR Robert H. Humphrey	ADDRESS Bethesda, Md.

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THE UNITED STATES

OF AMERICA

DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06894

CERTIFICATE OF DEATH

Reg. Dist. No. 216

Items 5, 6, 7, Film 6184 7-28-55 et

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) SOMERSET
TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5419 Uppingham St.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Mont
CITY (If outside corporate limits, write RURAL and give nearest town) SOMERSET
OR TOWN
STREET ADDRESS (If rural give location) 5419 Uppingham St.

3. NAME OF DECEASED:

(First) WALTER (Middle) H (Last) SCHOELLKOPF

4. DATE OF DEATH: (Month) 7 (Day) 15 (Year) 1955

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: OCT 18 1882

9. AGE last birthday. IF UNDER 1 YEAR IF UNDER 24 HRS. 72 yrs. Months Days Hour Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if 5 years

10b. KIND OF BUSINESS OR INDUSTRY: U.S. GOV'T

11. BIRTHPLACE (State or foreign country): Buffalo N.Y.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME:

LOUIS SCHOELLKOPF

14. MOTHER'S MAIDEN NAME:

MYRA L. HORTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) YES WWII

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

WALTER SCHOELLKOPF. Washington DC

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

42...
Immediate cause

(a) atherosclerotic heart disease
DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) ...
DUE TO

(024X)

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Tobacco use

Interval Between Onset And Death

5 years

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1953, to July 15, 1955, that I last saw the deceased

alive on July 10, 1955, and that death occurred at 2:15 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

IN RURAL CEMETERY, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

7.20.55

Bea M. Thompson

Wash. DC
Jos. Gawlers Sons 1756 Pa. Ave. NW

1955

1955

6972

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u> COUNTY <u>Nassamond</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN <u>Bethesda</u>		<u>159 days</u>		TOWN <u>Suffolk</u> <u>82 X 3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
50 <u>The Clinical Center Natl. Institutes of Health</u>				<u>110 Parkway</u> ✓			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)			
DECEASED: <u>James</u>		<u>Fielding</u> <u>SHEPHERD</u>		DATE: <u>July</u> <u>27</u> <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Aug. 28, 1896</u>	
9. AGE last birthday: <u>58 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Credit mgmt.</u>		11. BIRTHPLACE (State or foreign country): <u>Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>George Shepherd</u>				14. MOTHER'S MAIDEN NAME: <u>Bertha Bridwell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>							
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>190X</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Metastatic melanoma with brain stem compression</u>				<u>2/22/55</u>			
(B) <u>Metastatic melanoma</u>				<u>1948</u>			
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pulmonary metastases pneumonia, aspergillosis</u>							
19A. DATE OF OPERATION: <u>2/22/55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Melanoma, left temporal lobe</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>		21B. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 18, 1955</u> , to <u>July 27, 1955</u> , that I last saw the deceased alive on <u>July 27, 1955</u> , and that death occurred at <u>3 30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Jacob Robbins</u>		ADDRESS <u>M.D. Nat'l Inst. of Health</u>		DATE SIGNED <u>7/27/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial-transit</u>		DATE THEREOF <u>7/30/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Hollylawn</u>		LOCATION (City, town, or county) (State) <u>Nansemond Co. Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>8/1/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JOHN A. B.

1955

1955

69 '3

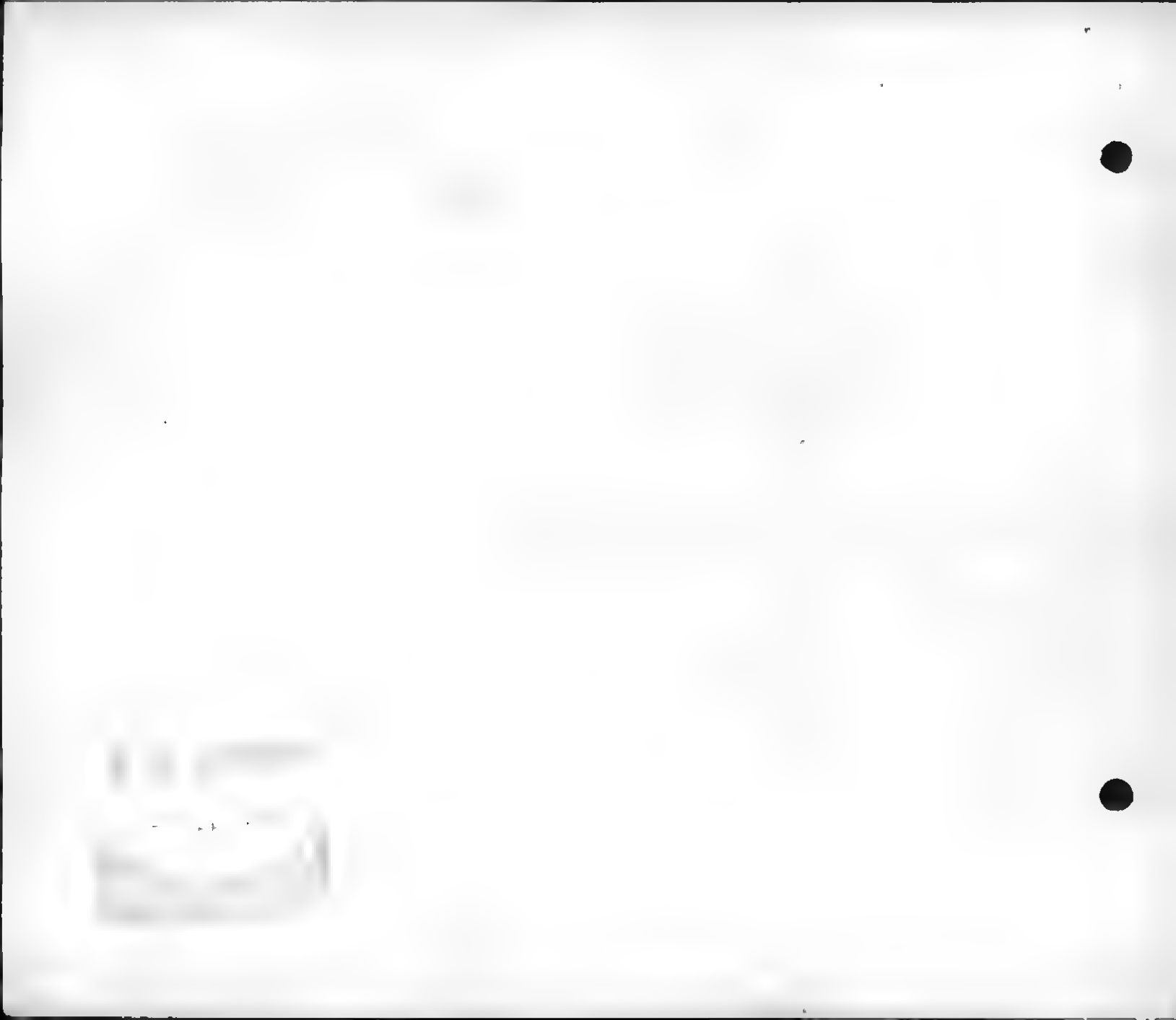
Item 9, Film 194 7-13-55 et

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Bethesda</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>8618 Irvington Ave.</u>			
3. NAME OF DECEASED: (First) <u>IDA</u> (Middle) <u>M</u> (Last) <u>SHIPP</u>				4. DATE OF DEATH: (Month) <u>July</u> (Day) <u>6</u> (Year) <u>1955</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Oct 20, 1879</u>	9. AGE last birthday: <u>75</u> yrs	10. IF UNDER 1 YEAR: Months	11. IF UNDER 24 HRS: Days	12. IF UNDER 60 HRS: Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>At home</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>	
13. FATHER'S NAME: <u>Patrick Willingham</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Mrs Vivian Trapani</u> <u>8618 Irvington Ave. Bethesda, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>acute congestive failure</u> DUE TO						<u>20 min.</u>	
ANTECEDENT CAUSE (B) <u>Coronary heart disease</u> DUE TO						<u>6 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>hypertension</u>						<u>Unk.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>15 May</u> , 19 <u>55</u> , to <u>6 July</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5 July</u> , 19 <u>55</u> , and that death occurred at <u>3:35 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>J. M. Thompson M.D.</u>		ADDRESS <u>7654 Georgetown Rd. Bethesda 14, Md.</u>		DATE SIGNED <u>6 July 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>7/9/55</u>		NAME OF CEMETERY OR CREMATORY <u>National Mem. Park Cem.</u>		LOCATION (City, town, or county) (State) <u>Falls Church, Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/7/55</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		ADDRESS <u>P. M. Lee's Sons Co. Wash. D.C.</u>			

MARGIN RESERVED FOR BINDING



6934

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY <u>Arlington</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Bethesda</u>		<u>101 days</u>		TOWN <u>Arlington</u>		<u>83 X - 3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u> <u>National Institutes of Health</u>				STREET ADDRESS (If rural give location) <u>4001 Litchfield Falls Road</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) <u>Ralph</u>		(Middle) <u>Dale</u>		(Last) <u>Snow</u>		(Month) (Day) (Year) <u>July 12 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>July 1, 1905</u>	9. AGE last birthday: <u>50</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Government employee</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Defense Department</u>		11. BIRTHPLACE (State or foreign country): <u>Utah</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Ralph F. Snow</u>				14. MOTHER'S MAIDEN NAME: <u>Martha Hornacks</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>							

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Carcinoma involving the face, orbit and base of the skull with metastases to skin & lung

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO

STATING UNDERLYING CAUSE LAST. (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: <u>April 21, 1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Extensive carcinoma of face, maxilla & nasal & oral cavities</u>		20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>None</u>		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>April 2, 1955</u> , to <u>July 12, 1955</u> , that I last saw the deceased alive on <u>July 12, 1955</u> , and that death occurred at <u>2:10 P.M.</u> from the causes and on the date stated above.					
SIGNATURE <u>Horace Herbsman</u>		ADDRESS <u>The Clinical Center</u> <u>M. D. National Institutes of Health</u>		DATE SIGNED <u>July 12, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/15/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
				LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-14-55</u>		REGISTRAR'S SIGNATURE <u>Beasie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>	
				ADDRESS <u>Bethesda, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 - 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8 8 87001

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06899

69 15

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY <u>Alexandria</u>	
CITY (If outside corporate limits, write RURAL OR TOWN) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>76 days</u>		CITY (If outside corporate limits, write RURAL OR TOWN) <u>Alexandria</u>		<u>83X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u>				STREET ADDRESS (If rural give location) <u>509 N. Howard</u>			
50							
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) <u>Antonio</u>		(Middle) <u>Cornelio</u>		(Last) <u>Sonneveldt</u>		DATE OF DEATH: <u>July 26</u> <u>19 55</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>May 18, 1917</u>	
				9. AGE last birthday <u>38</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Airline Employee</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Commerical Flying</u>		11. BIRTHPLACE (State or foreign country): <u>Argentina</u>		12. CITIZEN OF WHAT COUNTRY? <u>Argentina</u>	
13. FATHER'S NAME: <u>Anthonio Sonneveldt</u>				14. MOTHER'S MAIDEN NAME: <u>Metje Pruisen</u>			
15. WAS DECEASED EVER IN U.S. ARMY OR NAVY? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Aspiration pneumonia</u>							
ANTECEDENT CAUSE (B) <u>Malignant lymphoma</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>--</u>		19B. MAJOR FINDINGS OF OPERATION: <u>--</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>--</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>--</u>			
22. I hereby certify that I attended the deceased from <u>May 11, 1955</u> , to <u>July 26, 19 55</u> that I last saw the deceased alive on <u>July 26, 19 55</u> , and that death occurred at <u>8:05 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Bernie M. Thompson</u>		ADDRESS <u>The Clinical Center</u>		DATE SIGNED <u>7-27-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 29, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Montgomery County, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7/28/55</u>		REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Warner E. Thompson</u>		ADDRESS <u>Silver Spring, Md.</u>	

W. A. RICHARDSON

JUG 1

1914

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

06900

Reg. Dist. No. 216

6938

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE --		COUNTY --	
CITY (If outside corporate limits, write RURAL, OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington, D. C.			
X Bethesda		107 days		STREET ADDRESS (If rural give location) 2544 - 17th St. N.W., Apt. 3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS The Clinical Center Natl. Institutes of Health							
3. NAME OF DECEASED: (First) Bertha		(Middle) Dwan		(Last) Stamatis		4. DATE (Month) (Day) (Year) OF DEATH: July 8 1955	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: January 1, 1899		9. AGE last birthday 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY: --		11. BIRTHPLACE (State or foreign country): Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Ignatius Dwan				14. MOTHER'S MAIDEN NAME: Cora McIntyre			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT & ADDRESS: The medical record, The Clinical Center			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 153X Uremia associated with pyelonephritis, left							
ANTECEDENT CAUSE (S) (A) With an abscess in the left ilio-psoas muscle							
DUE TO Carcinoma of the colon metastatic to the peritoneum, lymph nodes, and to the tissue about the left ureter with obst. of the left ureter.							
(B)							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH Multiple perforations of the bowel with adhesions. Fibrinous pericarditis, multiple petechiae, skin, heart, intestine.							
19A. DATE OF OPERATION: April 5, 1955		19B. MAJOR FINDINGS OF OPERATION Recurrent & Metastatic cancer of colon with urinary bowel fistulae.					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) None		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Mar 23, 1955 , to July 8, 1955 , that I last saw the deceased alive on July 8, 1955 , and that death occurred at 12:50 PM , from the causes and on the date stated above.							
SIGNATURE J. Leonard Gold		ADDRESS The Clinical Center M. Divisional Institutes of Health		DATE SIGNED July 9, 1955			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 7-11-55		NAME OF CEMETERY OR CREMATORY Boston, Mass.		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR 7/9/55		REGISTRAR'S SIGNATURE Bessie M. Thompson		24. FUNERAL DIRECTOR Joseph Lawrence Long, Inc.		ADDRESS 1736 Pa. Ave. N.W.	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SECRET

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06901

6917

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH. U.S. Naval Hospital Bethesda COUNTY Montgomery MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda LENGTH OF STAY (in this place) 19 Days		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda	
51 HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Naval Hospital, NMMC, Bethesda 14, Md.		STREET ADDRESS (If rural give location) 4624 S. Chelsea Lane	
3. NAME OF DECEASED: (First) Louise (Middle) Wilton (Last) STEVENS		4. DATE (Month) (Day) (Year) OF DEATH July 16 19 55	
5. SEX Female	6. COLOR OR RACE Caucasian	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 10 July 1900
9. AGE last birthday 55 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: Ralph C. WILTON		14. MOTHER'S MAIDEN NAME: Amy L. FULLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT & ADDRESS. Ernest E. STEVENS 4624 S. Chelsea Lane, Bethesda, Md.			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 153X IMMEDIATE CAUSE (A) Secondary Shock ANTECEDENT CAUSE (B) Abdominal + pelvic Peritonitis DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Adeno Carcinoma, Cecum.			INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH Corticosteroid therapy + Atrophic Arthritis			3 mos 8 days
19A. DATE OF OPERATION: July 5, 1955 MAJOR FINDINGS OF OPERATION: Adeno Carcinoma, Cecum + Fracture Femur, Rt July 12, 1955 Wound Healed			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
22. I hereby certify that I attended the deceased from 26 June, 19 55 to 16 July, 19 55 that I last saw the deceased alive on 16 July, 19 55 , and that death occurred at 12:45 PM , from the causes and on the date stated above. SIGNATURE OF PHYSICIAN [Signature] ADDRESS U.S. Naval Hospital, NMMC, Bethesda, Maryland DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7-19-55	
NAME OF CEMETERY OR CREMATORY Arlington National		LOCATION (City, town, or county) (State) Arlington, Virginia	
DATE REC'D BY LOCAL REGISTRAR 7-16-55		REGISTRAR'S SIGNATURE [Signature]	
24. FUNERAL DIRECTOR R. A. PUMPHREY		ADDRESS 7557 Wis. Ave. Bethesda, Md.	

RECEIVED

JUL 10 1960



CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY MONTGOMERY	MARYLAND MD	STATE MD.	COUNTY MONTGOMERY
CITY (If outside corporate limits, write TOWN and give nearest town) BETHESDA	LENGTH OF STAY (in this place) 24 Yrs	CITY (If outside corporate limits, write TOWN and give nearest town) BETHESDA	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
		4700 SOUTH CHELSEA LANE	
3. NAME OF DECEASED: (Type or Print) GEORGE HENDERSON SWEET		4. DATE (Month) (Day) (Year) OF DEATH: JULY 24 1955	
5. SEX: M	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED	8. DATE OF BIRTH: AUG. 17, 1894
9. AGE last birthday: 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. GOVT		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: WILLIAM SWEET		14. MOTHER'S MAIDEN NAME: BELLE HURLBURT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No		16. SOCIAL SECURITY NO. No	
17. INFORMANT & ADDRESS: MRS. MAY DELANDER SWEET		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
154X IMMEDIATE CAUSE (A) Carcinomatosis		Days	
ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Carcinoma of rectum.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from July 24 1955 to July 24 1955 that I last saw the deceased alive on July 24 1955 , and that death occurred at 5:40 P.M. from the causes and on the date stated above.			
SIGNATURE George H. Gray Jr.		DATE SIGNED 7/24/55	
23. BURIAL, CREMATION, REMOVAL, (Specify): 7/26/55		NAME OF CEMETERY OR CREMATORY: St. Lincoln	
DATE REC'D BY LOCAL REGISTRAR: 7/28/55		REGISTRAR'S SIGNATURE: Bessie M. Thompson	
24. FUNERAL DIRECTOR: A. H. Hines Co		ADDRESS: 2901-14 St. NW	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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16 1 1955

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

69 '9

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06903

Reg. Dist.

No. 216

1. PLACE OF DEATH:

COUNTY Montgomery

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)
TOWN BethesdaLENGTH OF STAY
(in this place)
7 yearsHOSPITAL OR
INSTITUTION OR
STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY MontgomeryCITY (If outside corporate limits write RURAL and give nearest town)
TOWN 4527 Rosedale Ave. BethesdaSTREET ADDRESS (If rural, give location)
4527 Rosedale Ave.3. NAME OF
DECEASED:
(Type or Print)

(First)

LOUIS

(Middle)

ELMER

(Last)

TALBERT4. DATE
OF
DEATH

(Month)

July

(Day)

1

(Year)

1955

5. SEX:

Male6. COLOR OR
RACEWhite7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify):Married

8. DATE OF BIRTH:

5-5-1904

9. AGE last birthday:

51

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired):Ice business Owner-Ice bus.10b. KIND OF BUSINESS OR
INDUSTRY:11. BIRTHPLACE (State or foreign country):
Washington, D. C.12. CITIZEN OF WHAT
COUNTRY?U.S.

13. FATHER'S NAME:

Warren E. Talbert

14. MOTHER'S MAIDEN NAME:

Agnes R. Scott15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)
no

16. SOCIAL SECURITY No.:

579-14-1783

17. INFORMANT & ADDRESS:

4527 Rosedale Ave.
Anna May Talbert Bethesda, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a) DUE TO

Coronary occlusion

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating underlying cause last

(b) DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATHsuddenII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,
OF street, office bldg., etc.,
INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY21e. INJURY OCCURRED
While at Not while
work ☐ at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Dr. J. J. Prosch

CHIEF MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

7-1-55

M. D. ASSISTANT MEDICAL EXAM.

23. BURIAL, CREMATION,
REMOVAL (Specify)Burial

DATE THEREOF

7-6-1955

NAME OF CEMETERY OR CREMATORY

Ft. Lincoln Cem.

LOCATION (City, town, or county)

Prince George Co. Md

(State)

DATE REC'D BY LOCAL
REG.7/2/55

REGISTRAR'S SIGNATURE

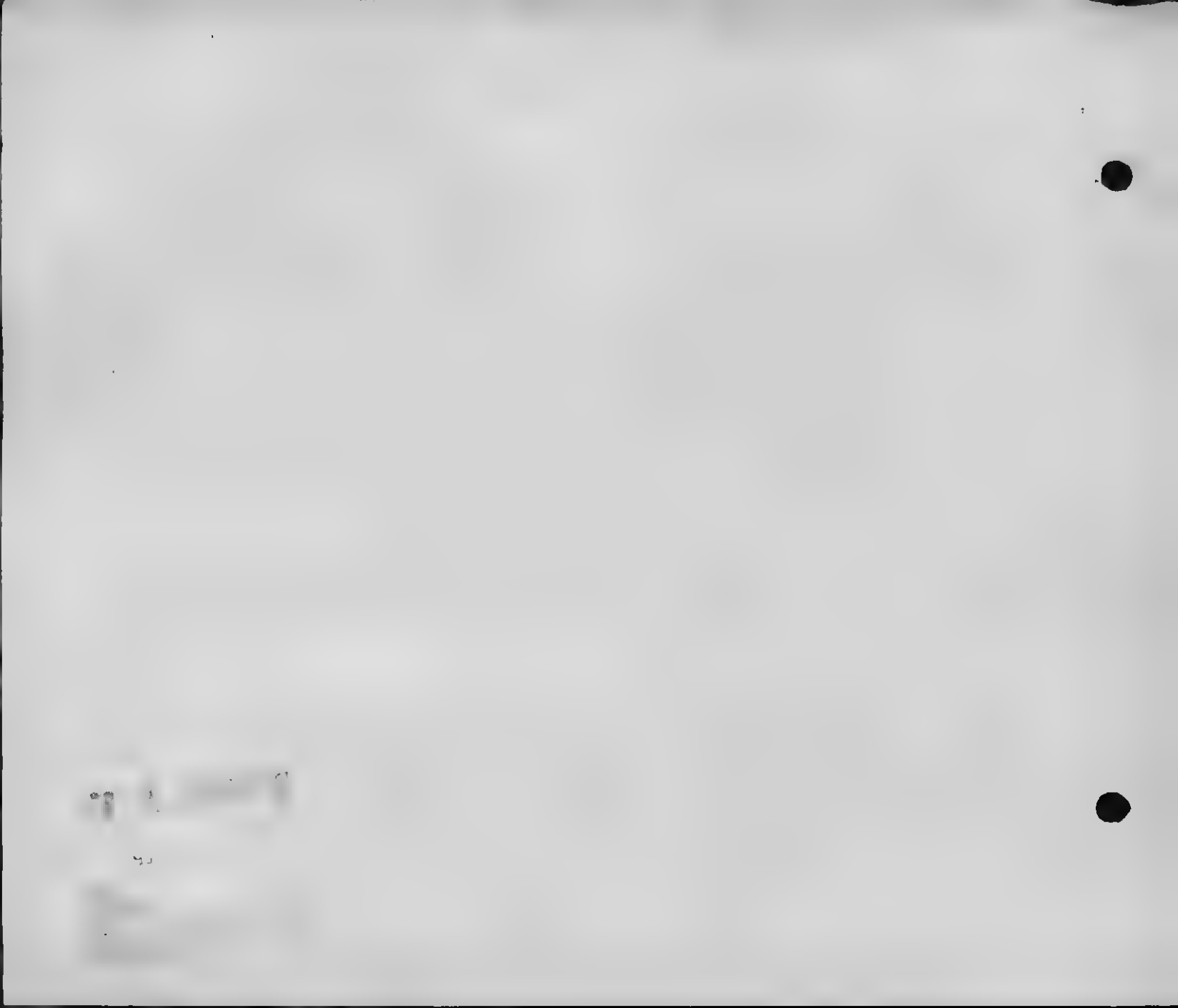
Beattie M. Thompson

24. FUNERAL DIRECTOR

Robert A. Humphrey

ADDRESS

Bethesda, Md



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06904
6910 CERTIFICATE OF DEATH Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>X</u> <u>Bethesda</u>		<u>111</u> days		<u>Silver Spring</u>		<u>56</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>56</u> <u>The Clinical Center</u> <u>National Institutes of Health</u>				<u>937 Bonifant St.</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)			
		<u>Delores Marie Thrush</u>		OF DEATH: <u>July 11</u> , 19 <u>55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>July 3, 1930</u>	<u>25</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Teacher</u>				<u>Education</u>		<u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY?				<u>U. S. A.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Joe Castello</u>				<u>Mary Mancino</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<u>no</u>				<u>Unknown</u>			
17. INFORMANT & ADDRESS:				<u>The medical record, The Clinical Center</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>609.0</u> IMMEDIATE CAUSE							
<u>Uremia</u> (A) DUE TO							
ANTECEDENT CAUSE (S)							
<u>? Chronic pyelonephritis</u> (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Sarcoma with destruction of pelvic bones</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>2</u>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Mar 22</u> , 19 <u>55</u> to <u>July 11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 11</u> , 19 <u>55</u> , and that death occurred at <u>4:00pM</u> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
<u>Martin Schick</u>				<u>The Clinical Center</u> <u>M. D. National Institutes of Health</u>		<u>July 12 '55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/14/55</u>		<u>Mt. Olivet Cemetery</u>		<u>Washington, D. C.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7-13-55</u>		<u>Beauregard M. Thompson</u>		<u>Warner & Pumphrey</u>		<u>8434 Ga. Ave.</u> <u>Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 670 Item 9, Film 185 8-30-55 et
CERTIFICATE OF DEATH

06905

Reg. Dist. No. 213

1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY
 OR and give nearest town) (in this place)
 TOWN Rockville - Md 5 yrs
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Chestnut Lodge 300 West Montgomery Ave

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Howard
 CITY (If outside corporate limits, write RURAL, and give nearest town)
 OR
 TOWN Baltimore 3V 1. 4
 STREET ADDRESS (If rural give location)
2701 Roslyn Ave

3. NAME OF DECEASED:

(First) (Middle) (Last)
Charlotte Amelia Tickner

4. DATE OF DEATH:

(Month) (Day) (Year)
July 22 1955

5. SEX:

F.

6. COLOR OR RACE:

N.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

WIDOWED

8. DATE OF BIRTH:

Aug 30, 1868

9. AGE last birthday: 12 UNDER 1 YEAR IF UNDER 24 HRS.

87 1/2 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):

House wife

10b. KIND OF BUSINESS OR INDUSTRY:

Baltimore

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME:

William Bewley

14. MOTHER'S MAIDEN NAME:

Charlotte Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

41XX
 Immediate cause

(a) Leukemia
 DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Senility
 DUE TO

(c) Hypertension

Interval Between Onset And Death
1 week

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

Hypertrophic cardiomyopathy

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
 OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from

, 1942 to 30 7 22 1955, that I last saw the deceased

alive on July 21, 1955, and that death occurred at

5130, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Burial
7-25-55
7/22/55

Druid Ridge
Laurel H. Taylor

Pikeville, Ind.
Wm. Tickner & Son, Balt., Ind.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THE JOURNAL OF

CERTIFICATE OF DEATH

Reg. Dist. No.

216

6911

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>West Va.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Bethesda</u>		<u>71 days</u>		OR TOWN <u>Fairmont</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Clinical Center</u>				STREET ADDRESS (If rural give location)			
<u>50 National Institutes of Health</u>				<u>516 Walnut Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		5. AGE last birthday		IF UNDER 1 YEAR	
<u>Mabel Mildred Toothman</u>		<u>July 27 19 55</u>		<u>41</u> yrs.		Months Days Hours Min.	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday		IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>October 18, 1913</u>	<u>41</u> yrs.		Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>---</u>		11. BIRTHPLACE (State or foreign country): <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Charles C. Parks</u>				14. MOTHER'S MAIDEN NAME: <u>Ora Wass</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>232-36-6075</u>		17. INFORMANT & ADDRESS: <u>The medical record, The Clinical Center</u>			
no							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>190X IMMEDIATE CAUSE</u>							
(A) <u>Cardiac arrest</u>							
DUE TO							
ANTECEDENT CAUSE (S)							
(B) <u>Malignant melanoma with widespread</u>							
DUE TO <u>metastases</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>---</u>		19B. MAJOR FINDINGS OF OPERATION: <u>---</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>---</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 17, 1955</u> , to <u>July 27, 1955</u> , that I last saw the deceased alive on <u>July 27, 1955</u> , and that death occurred at <u>7:15pM</u> , from the causes and on the date stated above.							
SIGNATURE <u>The Clinical Center</u>				DATE SIGNED <u>7/28/55</u>			
M. D. Nat'l Inst. of Health							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL & Removal</u>		<u>July 28, 1955</u>		<u>M. D. Nat'l Inst. of Health</u>		<u>FAIRMONT, West VA.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7/30/55</u>		<u>Bessie M. Thompson</u>		<u>Joseph Lawrence Jones</u>		<u>1756 R. Ave. NW. Wash. D.C.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUNNARD R. R.

AUG 2

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6912

06907

Reg. Dist. No. 216

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>California</u>		COUNTY	
CITY (If outside corporate limits, write OR and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>7-21-53/7-22-53</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Los Altos</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban</u>				STREET ADDRESS <u>12870 Roble Ave.</u>			
3. NAME OF DECEASED: (Type or Print) <u>Wyllie S. Treat</u>				4. DATE OF DEATH <u>July 22, 1955</u>			
5. SEX: <u>M.</u>		6. COLOR OR RACE: <u>W.</u>		8. DATE OF BIRTH: <u>12/26/20</u>		9. AGE last birthday: <u>34</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sanitary Corp</u>		11. BIRTHPLACE (State or foreign country): <u>Chicago, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Sidney W. Treat</u>				14. MOTHER'S MAIDEN NAME: <u>Katharine Louisa Baird</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>W.W. II.</u>		17. INFORMANT & ADDRESS: <u>Sidney W. Treat, Father</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
331X Immediate cause		(a) ... Extensive cerebral hemorrhage of mid brain and brain stem ...					
Antecedent cause(s)		(b) ... Marked hemorrhagic pneumonitis of both lungs					
Diseases or conditions, if any, giving rise to the above cause		DUE TO					
stating underlying cause last		(c) Cause undetermined					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>7-22-55</u>				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Bowers</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-22-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Cremation</u>		DATE THEREOF <u>7-22-55</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
DATE REC'D BY LOCAL REG. <u>7-23-55</u>		REGISTRAR'S SIGNATURE <u>Rebecca M. Thompson</u>		M. D. <u>Robert A. Smalley</u>		ADDRESS <u>Bethesda, Md.</u>	

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 2110

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Montg</u> | | MARYLAND | | STATE <u>ME</u> | | COUNTY <u>Montg</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits write RURAL and give nearest town) | | OR | |
| X TOWN <u>Bethesda</u> | | <u>ODA</u> | | TOWN <u>Garthursburg</u> | | X | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hosp</u> | | | | STREET ADDRESS (If rural, give location) <u>Diamond Ave</u> | | | |
| 3. NAME OF DECEASED: | | (First) (Middle) (Last) | | 4. DATE OF DEATH | | (Month) (Day) (Year) | |
| <u>Lucy</u> | | <u>Trevey</u> | | <u>July 16</u> | | <u>1955</u> | |
| 5. SEX: <u>Fe</u> | | 6. COLOR OR RACE: <u>W</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u> | | 8. DATE OF BIRTH: <u>July 27-1885</u> | |
| 9. AGE last birthday: <u>70</u> yrs. | | 10. BIRTHPLACE (State or foreign country): <u>Maryland</u> | | 11. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | 12. IF UNDER 1 YEAR IF UNDER 24 HRS | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY: <u>Housewife</u> | | 11. BIRTHPLACE (State or foreign country): <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME: <u>John B. Battlemay</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Sarah Thompson</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY No.: | | 17. INFORMANT & ADDRESS: <u>John Trevey, Garthursburg, Md</u> | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 331X Immediate cause (a) <u>Cerebral Vascular Accident</u> DUE TO | | | | | | <u>1/2 hr.</u> | |
| Antecedent cause(s) (b) <u>Hypertension</u> DUE TO | | | | | | <u>10 yrs.</u> | |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION: | | | | 19b. MAJOR FINDING OF OPERATION: | | | |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | | 21c. (City or town) (County) (State) | | | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| SIGNATURE <u>Frank J. Brochert</u> | | CHIEF MEDICAL EXAMINER | | DEPUTY MEDICAL EXAMINER | | DATE SIGNED <u>7-16-55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Buried</u> | | DATE THEREOF <u>7-19-55</u> | | NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u> | | LOCATION (City, town, or county) (State) <u>Garthursburg</u> <u>MD</u> | |
| DATE REC'D BY LOCAL REG. <u>Aug 20 55</u> | | REGISTRAR'S SIGNATURE <u>John M. Brochert</u> | | 24. FUNERAL DIRECTOR <u>James B. Garthursburg</u> | | ADDRESS <u>Garthursburg</u> | |

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1961

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

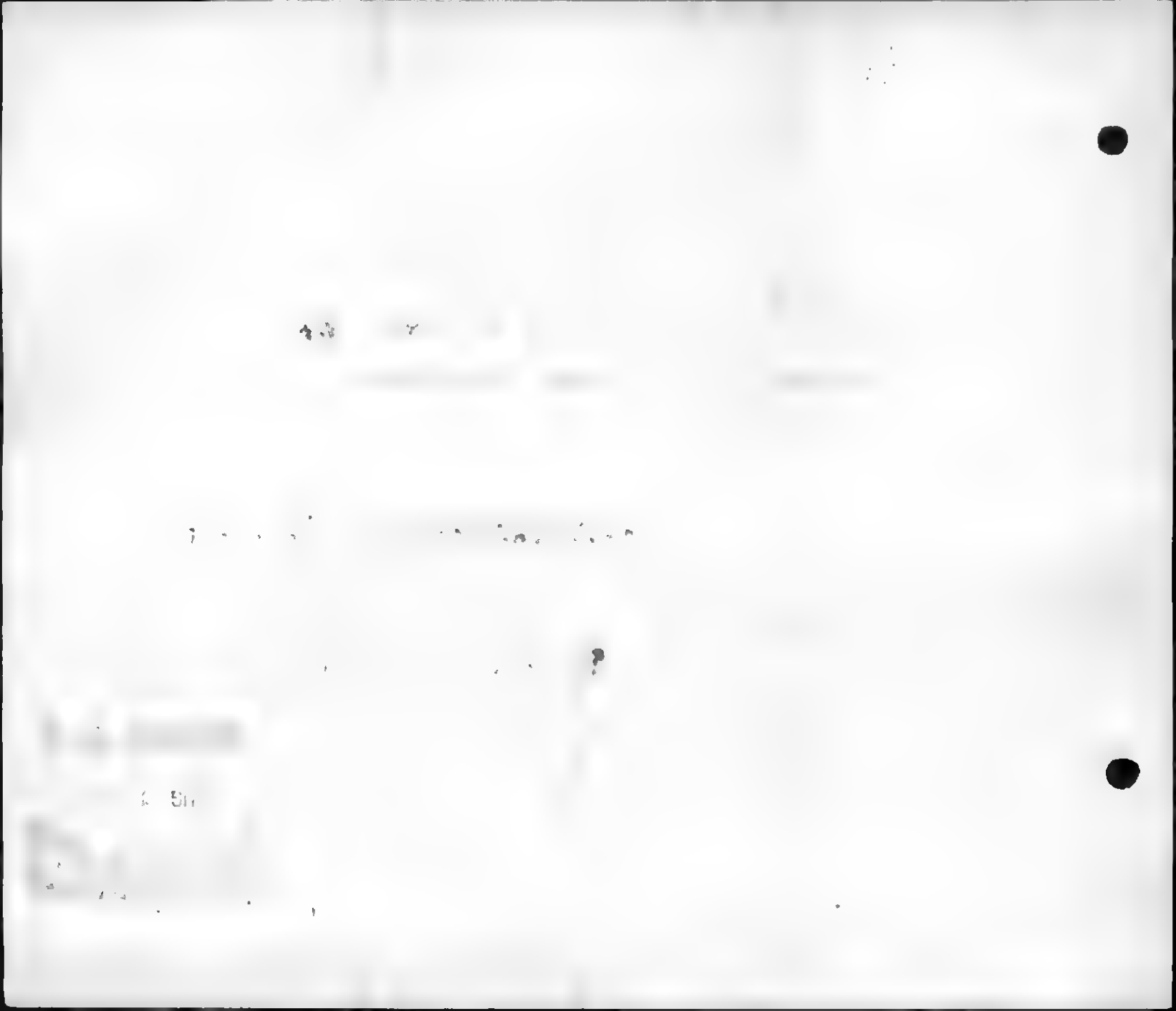
06909

6914

CERTIFICATE OF DEATH

Reg. Dist. No. 216...

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>MONTGOMERY</u> | MARYLAND | STATE <u>MD</u> | COUNTY <u>Montgo</u> |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>BETHESDA</u> | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u> | | STREET ADDRESS (If rural give location) <u>Dickerson, Md. R.F.D. 2</u> | |
| 3. NAME OF DECEASED: (Type or Print) <u>JOHN</u> (First) <u>TWYMAN</u> (Middle) (Last) | 4. DATE OF DEATH: <u>July 18</u> (Month) (Day) (Year) <u>1955</u> | | |
| 5. SEX: <u>MALE</u> <u>NEGR</u> 6. COLOR OR RACE: <u>NEGR</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u> 8. DATE OF BIRTH: <u>3-16-1889</u> 9. AGE last birthday <u>66</u> yrs. <u>66</u> Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u> | 10B. KIND OF BUSINESS OR INDUSTRY: <u>STATE ROADS</u> | 11. BIRTHPLACE (State or foreign country): <u>MONTGOMERY COUNTY, MD</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME: <u>George Twyman</u> | | 14. MOTHER'S MAIDEN NAME: <u>David Duggs</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> If Yes, give war or dates of service | | 16. SOCIAL SECURITY NO. <u>maia Twyman Dickerson, Md. (granddaughter)</u> | |
| 16. MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| IMMEDIATE CAUSE (A) <u>Cerebro-Vascular Accident</u> | | | |
| ANTECEDENT CAUSE (B) DUE TO | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pneumo-pneumonia</u> | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID (City or town) (County) (State) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>7/16, 1955</u> , to <u>7/18, 1955</u> , that I last saw the deceased alive on <u>7/18, 1955</u> , and that death occurred at <u>2nd</u> PM, from the causes and on the date stated above. | | | |
| SIGNATURE <u>Stephen C. Cromwell</u> | | ADDRESS <u>M.D. Rockville, Md.</u> DATE SIGNED <u>7/19/55</u> | |
| 23. BURIAL, CREMATION, DATE THEREOF REMOVAL (SPECIFY) <u>Final 7-23-55</u> | NAME OF CEMETERY OR CREMATORY <u>Warren Chapel</u> | | LOCATION (City, town, or county) (State) <u>Washington, Md</u> |
| DATE REC'D BY LOCAL REGISTRAR <u>7/28/55</u> | REGISTRAR'S SIGNATURE <u>Dr. M. H. Thompson</u> | 24. FUNERAL DIRECTOR <u>Robert L. Snowden</u> | ADDRESS <u>Rockville, Md</u> |



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06910

6915

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | |
|--|--------------------------------|--|--|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Montgomery</u> | MARYLAND | STATE <u>Maryland</u> | COUNTY <u>Montgomery</u> |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 6 days</u> | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Le Chevy Chase</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u> | | STREET ADDRESS (If rural give location) <u>4602 Merivale Rd.</u> | |
| 3. NAME OF DECEASED: (First) <u>Mary</u> (Middle) <u>Elizabeth</u> (Last) <u>Walker</u> | | 4. DATE OF DEATH: (Month) <u>July</u> (Day) <u>7</u> (Year) <u>1955</u> | |
| 5. SEX: <u>Female</u> | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH: <u>July 24, 1876</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>—</u> | 9. AGE last birthday: <u>79</u> yrs. <u>11</u> Months <u>13</u> Days |
| 11. BIRTHPLACE (State or foreign country): <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u> | |
| 13. FATHER'S NAME: <u>Henry C. Browning</u> | | 14. MOTHER'S MAIDEN NAME: <u>Ella Cawthorne</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <u>no</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.: <u>none</u> | |
| 17. INFORMANT & ADDRESS: <u>Mrs. Helen Lansdale Niece, 4602 Merivale Rd. Chevy Ch. Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| IMMEDIATE CAUSE (A) <u>Respiratory Failure</u> | | | <u>12 hrs</u> |
| ANTECEDENT CAUSE (B) <u>Acute Heart Failure - Dilated</u> | | | <u>2 days</u> |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Dehydration</u> | | | <u>2 days</u> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Advanced Arteriosclerosis</u> | | | <u>2 yrs.</u> |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, of injury street, office bldg., etc.) | |
| | | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>6/6, 1955</u> to <u>7/7, 1955</u> , that I last saw the deceased alive on <u>7/7, 1955</u> , and that death occurred at <u>7:15 A.M.</u> , from the causes and on the date stated above. | | | |
| SIGNATURE <u>Frank J. Jagger, Jr. M.D.</u> | | ADDRESS <u>5707 Wisconsin Ave. Chevy Chase, Md.</u> DATE SIGNED <u>7/7/55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>7-9-55</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u> | | LOCATION (City, town, or county) <u>Washington D. C.</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>7-12-55</u> | | REGISTRAR'S SIGNATURE <u>Robert A. Humphrey</u> | |
| 24. FUNERAL DIRECTOR | | ADDRESS <u>Bethesda, Md.</u> | |

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Items 2 & 9: Film G184 8/8-'5 Jmr.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06911

6916

CERTIFICATE OF DEATH

Reg. Dist. No. 216

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH: <u>Kennington Nursing Home</u> | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY: <u>Montgomery</u> | MARYLAND | STATE: <u>Maryland</u> | COUNTY: <u>Montgomery</u> |
| CITY (If outside corporate limits, write RURAL and give nearest town): <u>X Kennington</u> | LENGTH OF STAY (In this place): <u>2 days</u> | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: <u>Kennington Md</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: <u>3000 McComas Ave</u> | | STREET ADDRESS: <u>4109 Franklin St</u> | (If rural give location): <u>Chase Park</u> |
| 3. NAME OF DECEASED: (First) <u>Campbell</u> (Middle) <u>Easton</u> (Last) <u>Waters</u> | | 4. DATE (Month) (Day) (Year) OF DEATH: <u>7 29 1955</u> | |
| 5. SEX: <u>Male</u> | 6. COLOR OR RACE: <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u> | 8. DATE OF BIRTH: <u>Sept. 14-1872</u> |
| 9A. AGE last birthday: <u>83</u> | | IF UNDER 1 YEAR: Months <u>10</u> Days <u>15</u> Hours <u></u> Min. <u></u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Chemist for U.S. Gov.</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: <u></u> | |
| 11. BIRTHPLACE (State or foreign country): <u>Balto. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME: <u>Chas. Emory Waters</u> | | 14. MOTHER'S MAIDEN NAME: <u>Annie Easter</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If yes, give war or dates of service): <u></u> | | 16. SOCIAL SECURITY NO.: <u></u> | |
| 17. INFORMANT & ADDRESS: <u></u> | | | |
| 18. MEDICAL CERTIFICATION | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (A) <u>Acute Congestive Myocardial Failure</u> | | <u>12 hrs.</u> | |
| ANTECEDENT CAUSE (B) <u>Arteriosclerosis, Generalised, Advanced</u> | | <u>5 yrs.</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>Right Hemiplegia with aphasia, severe</u> | | <u>6 wks.</u> | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: <u></u> | | 19B. MAJOR FINDINGS OF OPERATION: <u></u> | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u></u> | |
| 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u></u> | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u></u> | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? <u></u> | | | |
| 22. I hereby certify that I attended the deceased from <u>1950</u> , to <u>July 29, 1955</u> , that I last saw the deceased alive on <u>July 29, 1955</u> , and that death occurred at <u>11¹⁵ P.M.</u> from the causes and on the date stated above. | | | |
| SIGNATURE: <u>Stewart Elaff</u> | | DATE SIGNED: <u>July 30, 1955</u> | |
| M. D. <u>3921 Ingomar Sp. W.</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Cremation</u> | | DATE THEREOF: <u>7-30-55</u> | |
| NAME OF CEMETERY OR CREMATORY: <u>Cedar Hill Crematory</u> | | LOCATION (City, town, or county) (State): <u>Prince George Co., Md.</u> | |
| DATE REC'D BY LOCAL REGISTRAR: <u>8/1/55</u> | | REGISTRAR'S SIGNATURE: <u>Beattie M. Thompson</u> | |
| 24. FUNERAL DIRECTOR: <u>Robert A. Zumbach</u> | | ADDRESS: <u>Be the sda, Md.</u> | |

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6917
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06912
Reg. Dist. No. 214

| | | | | | | | |
|---|--|--|--|--|--|---|---|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Montgomery</u> | | MARYLAND | | STATE <u>MD</u> | | COUNTY <u>Montg</u> | |
| CITY (If outside corporate limits, write OR and give nearest town)
TOWN <u>Silver Spring</u> | | LENGTH OF STAY (in this place)
<u>8 mo.</u> | | CITY (If outside corporate limits write RURAL and give nearest town)
TOWN <u>Silver Spring</u> | | <u>56</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3011 Medway St</u> | | | | STREET ADDRESS (If rural, give location)
<u>3011 Medway St.</u> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last)
(Type or Print) <u>William Philip Waters</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year)
<u>July 16 1955</u> | | | |
| 5. SEX:
<u>M</u> | | 6. COLOR OR RACE:
<u>W</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
<u>married</u> | | 8. DATE OF BIRTH:
<u>2-22-'96</u> | |
| 9. AGE last birthday:
<u>59</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):
<u>Salesman</u> | | 11. BIRTHPLACE (State or foreign country):
<u>Md</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME:
<u>unknown</u> | | | | 14. MOTHER'S MAIDEN NAME:
<u>unknown</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>yes</u> | | 16. SOCIAL SECURITY No.:
<u>424-09-7654</u> | | 17. INFORMANT & ADDRESS:
<u>Virginia Waters (wife) Home as item 2</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | | | |
| Immediate cause (a) <u>Coronary occlusion</u>
DUE TO
Antecedent cause(s) (b)
Diseases or conditions, if any, giving rise to the above cause DUE TO
stating <u>underlying cause last</u> (c) | | | | | | | <u>sudden death</u> |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION:
<u>11</u> | | 19b. MAJOR FINDING OF OPERATION: | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | | 21c. (City or town, (County) (State) | | | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.
SIGNATURE <u>Francis J. Broschard Post Mortem Examiner</u>
CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-16-55</u>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAM. <input type="checkbox"/> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify):
<u>BURIAL</u> | | DATE THEREOF
<u>7-19-55</u> | | NAME OF CEMETERY OR CREMATORY
<u>BALTIMORE</u> | | LOCATION (City, town, County, State)
<u>BALTIMORE</u> | |
| DATE REC'D BY LOCAL REG.
<u>7-18-55</u> | | REGISTRAR'S SIGNATURE
<u>Francis J. Broschard</u> | | 24. FUNERAL DIRECTOR
<u>THE S. H. HINES CO.</u>
<u>1901-14th St. N.W. WASH. D. C.</u> | | | |

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6788

CERTIFICATE OF DEATH

Reg. Dist. No. 223

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED. | |
| COUNTY <u>Montgomery</u> MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town)
OR <u>Takoma Park</u>
TOWN <u>17 days</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Sanitarium Hospital</u> | STATE <u>Maryland</u> COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town)
OR <u>Silver Spring</u>
TOWN <u>56</u>
STREET ADDRESS (If rural give location)
<u>544 Beacon Rd.</u> | | |
| 3. NAME OF DECEASED:
(Type or Print) <u>Mabel Alice Welles</u> | | 4. DATE (Month) (Day) (Year)
OF DEATH: <u>7 - 4 1955</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE: <u>Caucasian</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u> | 8. DATE OF BIRTH: <u>Nov. 12 - 1886</u> |
| 9. AGE at birthday <u>69</u> yrs. Months Days Hours Min. | | 10. BIRTHPLACE (State or foreign country): <u>New York</u> | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>Wm. Schnurr</u> | | 14. MOTHER'S MAIDEN NAME: <u>Hannah Hobley</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | |
| 17. INFORMANT & ADDRESS: <u>Hospital Records</u> | | | |
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| (A) IMMEDIATE CAUSE <u>Broncho-Pneumonia Secondary to</u> | | <u>2 weeks</u> | |
| (B) ANTECEDENT CAUSE (S) <u>General Nervousness</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST | | (C) <u>Generalized Osteomyelitis of Neck of Femur</u> | |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Extremes Neck</u> | | | |
| 19A. DATE OF OPERATION: | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 19B. MAJOR FINDINGS OF OPERATION | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>May 15, 1955</u> to <u>July 4, 1955</u> , that I last saw the deceased alive on <u>July 3, 1955</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above. | | | |
| SIGNATURE <u>Thomas J. Quinn M.D.</u> | | DATE SIGNED <u>July 4/55</u> | |
| M.D. <u>501-2 Constitution Ave. Washington D.C.</u> | | (State) <u>D.C.</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | DATE THEREOF <u>7-6-55</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u> | | ADDRESS <u>Washington D.C.</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>July 4 1955</u> | | 24. FUNERAL DIRECTOR <u>The St. James Co.</u> | |
| REGISTRAR'S SIGNATURE <u>J. H. Quinn</u> | | ADDRESS <u>2901-14th Ave. N.W. Washington D.C.</u> | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

January
1900

6918

CERTIFICATE OF DEATH

Reg. Dist. No. 211

| | | | | | | | |
|---|--|-----------------------------------|--|--|--|------------------------------|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <i>Montgomery</i> | | MARYLAND | | STATE | | COUNTY <i>47X-3</i> | |
| CITY (If outside corporate limits, write OR and give nearest town) <i>Clarkesburg</i> | | | | CITY (If outside corporate limits, write OR and give nearest town) <i>Washington, D.C.</i> | | | |
| TOWN <i>Clarkesburg</i> | | | | TOWN <i>Washington, D.C.</i> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS <i>4336 Southern Ave. S.E.</i> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | | 4. DATE OF DEATH: (Month) (Day) (Year) | | | |
| <i>SARAH GRACE CECELIA WELSH</i> | | | | <i>7 - 12 1955</i> | | | |
| 5. SEX: | | 6. COLOR OR RACE: | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | | 8. DATE OF BIRTH: | |
| <i>Female</i> | | <i>White</i> | | <i>Widowed</i> | | <i>6-20-1891</i> | |
| 9a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: | | 9b. KIND OF BUSINESS OR INDUSTRY: | | 9c. AGE last birthday: (If UNDER 1 YEAR) (If UNDER 24 HRS.) | | 10. CITIZEN OF WHAT COUNTRY: | |
| <i>Housewife in own home</i> | | <i>Washington, D.C.</i> | | <i>64 yrs.</i> | | <i>U.S.A.</i> | |
| 11. FATHER'S NAME: | | | | 12. MOTHER'S MAIDEN NAME: | | | |
| <i>Wilbur Kiplinger</i> | | | | <i>Margaret Shugrue</i> | | | |
| 13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 14. SOCIAL SECURITY No.: | | | |
| <i>no</i> | | | | <i>none</i> | | | |
| 15. INFORMANT & ADDRESS: | | | | 16. MEDICAL CERTIFICATION | | | |
| <i>Margaret Reedel Clarkesburg Md</i> | | | | 17. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| | | | | 18. Immediate cause | | | |
| | | | | (a) <i>Arteriosclerotic cardiovascular disease</i> | | | |
| | | | | DUE TO | | | |
| | | | | (b) <i>Renal calculi</i> | | | |
| | | | | DUE TO | | | |
| | | | | (c) | | | |
| 19. OTHER SIGNIFICANT CONDITIONS | | | | 20. AUTOPSY? | | | |
| Conditions contributing to the death but not related to the disease or condition causing death. | | | | Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| 21. DATE OF OPERATION: | | | | 22. MAJOR FINDINGS OF OPERATION | | | |
| | | | | | | | |
| 23. ACCIDENT (Specify) | | | | 24. PLACE (Home, farm, factory, street, office bldg., etc.) | | | |
| SUICIDE | | | | (CITY OR TOWN) | | | |
| HOMICIDE | | | | (COUNTY) | | | |
| | | | | (STATE) | | | |
| TIME (Month) (Day) (Year) (Hour) | | | | INJURY OCCURRED | | | |
| OF INJURY | | | | While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| | | | | HOW DID INJURY OCCUR? | | | |
| 25. I hereby certify that I attended the deceased from <i>7/12</i> , 19 <i>55</i> , to <i>7/12</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>7/12</i> , 19 <i>55</i> , and that death occurred at <i>10:30 p.m.</i> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>James P. Kerr M.D.</i> | | | | DATE SIGNED <i>7/12/55</i> | | | |
| ADDRESS <i>Damascus, Md.</i> | | | | | | | |
| 26. BURIAL, CREMATION, REMOVAL (Specify) | | | | 27. DATE THEREOF | | | |
| <i>Burial</i> | | | | <i>8-15-1955</i> | | | |
| 28. NAME OF CEMETERY OR CREMATORY | | | | 29. LOCATION (City, town, or county) (State) | | | |
| <i>Bedar Hill Cemetery</i> | | | | <i>Southland, Md.</i> | | | |
| 30. DATE REC'D BY LOCAL REGISTRAR | | | | 31. REGISTRAR'S SIGNATURE | | | |
| <i>July 13, 1955</i> | | | | <i>Della W. Burdette</i> | | | |
| 32. FUNERAL DIRECTOR | | | | 33. ADDRESS | | | |
| <i>Valley's Funeral Home</i> | | | | <i>3200-R. 8 Ave. Mt. Rainier, Md.</i> | | | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 216

6915

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Montgomery</u> MARYLAND | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u> LENGTH OF STAY (in this place) <u>14 days</u> | STATE <u>D.C.</u> COUNTY <u>Washington</u> | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> |
| TOWN <u>X</u> | HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u> | TOWN <u>Washington</u> | STREET ADDRESS (If rural, give location) <u>5266 - River Rd.</u> |
| 3. NAME OF DECEASED (Type or Print) | (First) <u>Malochi</u> (Middle) <u>William</u> (Last) <u>Williams</u> | 4. DATE OF DEATH (Month) <u>July</u> (Day) <u>4</u> (Year) <u>1955</u> | |
| 5. SEX: <u>Male</u> | 6. COLOR OR RACE: <u>Latino</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Feb. 2, 1883</u> |
| | | 9. AGE last birthday <u>72</u> yrs | 10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>2</u> Hours <u>12</u> Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Labourer</u> | 10B. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): <u>Virginia</u> | 12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u> |
| 13. FATHER'S NAME: | 14. MOTHER'S MAIDEN NAME: <u>Emma Williams</u> | 17. INFORMANT & ADDRESS: <u>Mrs. Mary Williams 5266 - River Rd. Wash. D.C.</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 15. MEDICAL CERTIFICATION | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (A) <u>Encephalomalacia, & infection</u> | | <u>1 wk ?</u> | |
| ANTECEDENT CAUSE (B) <u>Rt. cerebral hemisphere</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Thrombosis, Rt. middle cerebral artery</u> | | <u>1 wk ?</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>July 1, 1955</u> , to <u>July 4, 1955</u> , that I last saw the deceased alive on <u>July 4, 1955</u> and that death occurred at <u>2:45 AM</u> , from the causes and on the date stated above. | | | |
| SIGNATURE <u>Stephen C. Cromwell</u> | | ADDRESS <u>W.D. - Rockville, Md.</u> | DATE SIGNED <u>7/4/55</u> |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF <u>7/7/55</u> | NAME OF CEMETERY OR CREMATORY <u>Wood Lawn C</u> | LOCATION (City, town, or county) (State) <u>D.C.</u> |
| DATE REC'D BY LOCAL REGISTRAR <u>7/6/55</u> | REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u> | 24. FUNERAL DIRECTOR <u>William J. Miller</u> | ADDRESS <u>2218, 12</u> |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NEW YORK N.Y.

JUL 8 1965



6920

CERTIFICATE OF DEATH

Reg. Dist. No. 217

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN <u>Olney</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>General Hospital, Inc.</u> | MARYLAND
LENGTH OF STAY (in this place) <u>5 days</u> | STATE <u>Maryland</u> COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rockville</u>
STREET ADDRESS (If rural give location) <u>10 Williams St.</u> | |
| 3. NAME OF DECEASED: (First) <u>Walter</u> (Middle) <u>Anderson</u> (Last) <u>Williams</u> | | 4. DATE (Month) (Day) (Year) OF DEATH: <u>July 13 1955</u> | |
| 5. SEX: <u>Male</u> COLOR OR RACE: <u>White</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u> | |
| 6. DATE OF BIRTH: <u>1/19/1874</u> | | 8. AGE last birthday: <u>81</u> yrs. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Government</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>employee (District)</u> | |
| 11. BIRTHPLACE (State or foreign country): <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>Richard M. Williams</u> | | 14. MOTHER'S MAIDEN NAME: <u>Rose Anderson</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT & ADDRESS: <u>Hospital Record</u> | | | |
| 18. MEDICAL CERTIFICATION | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 2040
IMMEDIATE CAUSE
(A) <u>Acute lymphatic leukemia</u>
DUE TO | | <u>Few weeks</u> | |
| ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
(B) <u>Terminal right hemiplegia</u>
DUE TO
(C) <u>Bronchopneumonia, congestive</u> | | <u>4 days</u>
<u>4 days</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: <u>None</u> | | 19B. MAJOR FINDINGS OF OPERATION | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>1/8/30</u> , 19, to <u>7/13/55</u> 19 .., that I last saw the deceased alive on <u>7/12/55</u> , 19 .., and that death occurred at <u>6:50aM</u> , from the causes and on the date stated above. | | | |
| SIGNATURE <u>W. B. Finkbeiner</u> | | DATE SIGNED <u>7/13/55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>7-15-55</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u> | | LOCATION (City, town, or county) (State) <u>Rockville, Md.</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>7-13-55</u> | | REGISTRAR'S SIGNATURE <u>Gertrude B. Lawler</u> | |
| FUNERAL DIRECTOR <u>Robert A. Runyphing</u> | | ADDRESS <u>Bethesda, Md.</u> | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5 A 050000

12 1000

050000

6789

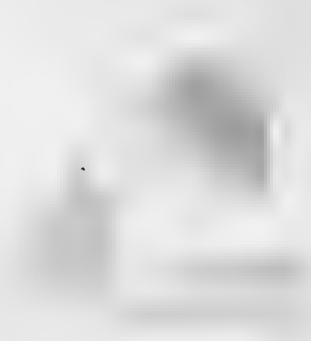
CERTIFICATE OF DEATH

Reg. Dist. No. 223

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Montgomery</u> | MARYLAND | STATE <u>District of Columbia</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | |
| 17 TOWN <u>Takoma Park</u> | 17 days | Washington, D.C. 478 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural give location) | |
| 25 <u>Washington Sanatorium Hosp.</u> | | 538 Peabody St. N.W. | |
| 3 NAME OF DECEASED (Type or Print) | First (Middle) (Last) | 4. DATE (Month) (Day) (Year) | |
| Harriet | Hilda A. Harrison | OF DEATH: 7/26 1955 | |
| 5. SEX. F | 6. COLOR OR RACE. White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed | 8. DATE OF BIRTH. 2/2/75 |
| 9. AGE last birthday. 80 yrs. | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife | 10B. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): Canada |
| 12. CITIZEN OF WHAT COUNTRY? | 13. FATHER'S NAME: Frederick Sutton | 14. MOTHER'S MAIDEN NAME: Catherine Joseph | 17. INFORMANT & ADDRESS: Hospital Record |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | 16. SOCIAL SECURITY NO. | 18. MEDICAL CERTIFICATION | |
| 19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | IMMEDIATE CAUSE | | INTERVAL BETWEEN ONSET AND DEATH |
| 420.0 | (A) Bronchopneumonia | | 5 days |
| ANTECEDENT CAUSE (S): | (B) Congestive Heart Failure | | 1 week |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST | (C) Arteriosclerotic Heart Disease | | 4 1/2 yr |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION. | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID (City or town) INJURY OCCUR? (County) (State) | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from July 5, 1955, to July 26, 1955, that I last saw the deceased alive on July 26, 1955, and that death occurred at 1 PM, from the causes and on the date stated above. | | | |
| SIGNATURE | ADDRESS | DATE SIGNED | |
| H. S. Orleans & H. T. Morn M.D. | 7800 Carroll Ave - NW | 7/26/55 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
| Burial | 7-29-55 | Congressional Cem. | Washington D.C. |
| DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
| July 26-1955 | J. Nelson Dodels | Local Funeral Home | 4812 Johnson St. DC |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



U.S. DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6921

06918

Reg. Dist. No. 211

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|--|-------------------|---|----------------------|--|-----------------|--|------------------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Montgomery</u> | | MARYLAND | | STATE <u>md</u> | | COUNTY <u>Montg</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | | | CITY (If outside corporate limits write RURAL and give nearest town) | | | |
| X TOWN <u>mt city - RFD #3</u> | | <u>1 1/2 hr</u> | | TOWN <u>Damascus</u> | | X | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Brown Church R</u> | | | | STREET ADDRESS (If rural, give location) <u>1</u> | | | |
| 3. NAME OF DECEASED: | | (First) (Middle) (Last) | | 4. DATE OF DEATH | | (Month) (Day) (Year) | |
| (Type or Print) | | <u>Robert Leo Windsor</u> | | <u>July 1</u> | | <u>19 55</u> | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Male</u> | <u>White</u> | <u>Married</u> | <u>June 15, 1922</u> | <u>33</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): | | 10b. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Painter - Army Medical Center</u> | | <u>Medical Center</u> | | <u>Ridgeville, Md.</u> | | <u>USA</u> | |
| 13. FATHER'S NAME: | | | | 14. MOTHER'S MAIDEN NAME: | | | |
| <u>Robert I. Windsor</u> | | | | <u>Lucinda Watkins</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY No.: | | 17. INFORMANT & ADDRESS: | | | |
| <u>yes</u> ✓ (If Yes, give war or dates of service) <u>WW 2</u> | | <u>577-24-0667</u> | | <u>Mrs Robert L. Windsor, Damascus, Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| Immediate cause (a) <u>Asphyxia</u> | | | | | | <u>seconds</u> | |
| DUE TO | | | | | | | |
| Antecedent cause(s) (b) <u>drowning</u> | | | | | | | |
| Diseases or conditions, if any, giving rise to the above cause DUE TO | | | | | | | |
| stating underlying cause last (c) | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDING OF OPERATION: | | | | | |
| <u>11-1-55</u> | | <u>mt city RFD #3 Montg md</u> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, OF street, office bldg, etc.) INJURY: <u>farm & rd</u> | | 21c. (City or town) (County) (State) | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7-1-55 8 P.M.</u> | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | <u>mt city RFD #3 Montg md</u> | | | |
| | | | | <u>drown while swimming</u> | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| SIGNATURE | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Frank J. Prosser</u> | | <u>July 4, 1955</u> | | <u>Damascus</u> | | <u>Damascus, Md.</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): | | DATE REC'D BY LOCAL REG. | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR ADDRESS | |
| <u>Burial</u> | | <u>7/3/55</u> | | <u>Della W. Burdette</u> | | <u>Clin L. Molesworth, Damascus, Md.</u> | |



100-100000
100-100000
100-100000

C795

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

COUNTY Montgomery

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

26 Rockville

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

12916 Ardennes Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Montgomery

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN Rockville 26

STREET ADDRESS (If rural, give location)

12916 Ardennes Ave.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

HELENE MARIE WOLF

4. DATE

(Month)

(Day)

(Year)

OF

DEATH:

July 4, 1955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS

Female

WhiteWidowedMay 27, 188075

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

Own Home

11. BIRTHPLACE (State or foreign country):

Germany

12. CITIZEN OF WHAT COUNTRY?

US

13. FATHER'S NAME:

J. Hinrich Johansen

14. MOTHER'S MAIDEN NAME:

Ilse Dres

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Mrs Wilbur R. Gordon-Item# 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

157X

Immediate cause

(a)

DUE TO

Generalized Carcinomatosis

INTERVAL BETWEEN ONSET AND DEATH

2 1/2 mos.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

Carcinoma, head of pancreas1 yr

(c)

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1955, to July 1955, that I last saw the deceased alive on July, 1955, and that death occurred at 6:20 p.m., from the causes and on the date stated above.SIGNATURE 36 June 55

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

W. H. HallMDRockville, Md7/4/55

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial-Transit DATE REC'D BY LOCAL REG. 7/11/55

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Laurel St. GragoryRobert M. CampbellBethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BUCKLE UP

JUL 14 1955



CERTIFICATE OF DEATH

Reg. Dist. No.

216

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Montgomery</u> | MARYLAND | STATE <u>D.C.</u> | COUNTY |
| CITY (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | LENGTH OF STAY (in this place)
<u>14 days</u> | CITY (If outside corporate limits, write RURAL and give nearest town)
<u>WASHINGTON</u> | <u>47X-3</u> |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
<u>Suburban Hospital</u> | | STREET ADDRESS
<u>2318 Franklin St. NW</u> | |
| 3. NAME OF DECEASED:
(Type or Print) | (First) (Middle) (Last) | 4. DATE OF DEATH: | (Month) (Day) (Year) |
| <u>Marcelles D'Orfe</u> | | <u>July 14</u> | <u>1955</u> |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH: |
| <u>M</u> | <u>W</u> | <u>Married</u> | <u>Aug. 26, 1882</u> |
| 9. AGE last birthday | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
| <u>72</u> | <u>Switchboard Operator</u> | <u>INDIA</u> | <u>U.S.A.</u> |
| 13. FATHER'S NAME: | 14. MOTHER'S MAIDEN NAME: | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) | 16. SOCIAL SECURITY No. |
| <u>John A. D'Orfe</u> | <u>Marcelles D'Orfe</u> | | |
| 17. INFORMANT & ADDRESS: | | 18. MEDICAL CERTIFICATION | |
| <u>Fred W. Winkelman, 3018 IPWISON ST. NW, WASH. D.C.</u> | | I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | |
| | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | IMMEDIATE CAUSE | |
| | | ANTECEDENT CAUSE (S) | |
| | | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST | |
| | | (A) <u>Adenocarcinoma Metastatic Lung</u> | |
| | | DUE TO <u>primaries lymph nodes, pericarditis</u> | |
| | | (B) <u>base, pleura, bilateral</u> | |
| | | DATE TO <u>Adenocarcinoma, Head of Pancreas</u> | |
| | | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | |
| <u>7/16/55</u> | | | |
| 20. AUTOPSY? | | | |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID (City or town) INJURY OCCUR? | (County) (State) |
| | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED While at work Not while at work | 21F. HOW DID INJURY OCCUR? | |
| | | | |
| 22. I hereby certify that I attended the deceased from <u>6/30</u> , 19 <u>55</u> , to <u>7/16</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6/14</u> , 19 <u>55</u> , and that death occurred at <u>7:45</u> AM, from the causes and on the date stated above. | | | |
| SIGNATURE <u>John B. Winkelman</u> | | DATE SIGNED <u>7/16/55</u> | |
| ADDRESS <u>M. D. 8805 Conn. Ave. N.W.</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
| <u>Burial</u> | <u>7-18-55</u> | <u>Rock Creek</u> | <u>Washington D.C.</u> |
| DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
| <u>7-16-55</u> | <u>Bessie M. Thompson</u> | <u>S.H. Hines Co</u> | <u>2901 14th St. NW</u> |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3-10-1970

JUL 1970

107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06021

Reg. Dist. No. 223-

Item 9. Film G185 8-16-55 et

| | | | |
|---|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH
COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED
STATE <u>MARYLAND</u> <u>PRINCE GEORGES</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>1700 Hudson Rd</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>College Park, Md</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Takoma Park, Md</u> | | STREET ADDRESS <u>8907 Falls Ave</u> | |
| 3. NAME OF DECEASED
(Type or Print) <u>Nellie ONTHANK Wooster</u> | | 4. DATE OF DEATH
(Month) <u>July</u> (Day) <u>3</u> (Year) <u>1955</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>July 21, 1869</u> |
| 9. AGE last birthday <u>86</u> yrs. | | 10. BIRTHPLACE (State or foreign country) <u>Illinois</u> | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Chas H. Onthank</u> | | 14. MOTHER'S MAIDEN NAME <u>Helen McDonald</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY No. <u>1402-1-10000</u> | |
| 17. INFORMANT AND ADDRESS <u>M.W. Wooster 1402-1-10000 Hyattsville</u> | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0
Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Chronic Congestive Heart Failure
(b) Broncho pneumonia
(c) Generalized Atherosclerosis

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

| | | | | | |
|--|--|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 21. ACCIDENT (Specify) <u>Heart</u> | | PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u> | | (CITY OR TOWN) (COUNTY) (STATE) | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | | HOW DID INJURY OCCUR? | |

22. I hereby certify that I attended the deceased from July 2, 1955 to July 3, 1955, that I last saw the deceased alive on July 2, 1955, and that death occurred at 9:30 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | | DATE THEREOF <u>7/10/55</u> | | NAME OF CEMETERY OR CREMATORY <u>Lot Lincoln</u> | | LOCATION (City, town, or county) (State) <u>College Park, Md</u> | |
| DATE REC'D BY LOCAL REG <u>July 4, 1955</u> | | REGISTRAR'S SIGNATURE <u>J. H. Smith</u> | | 24. FUNERAL DIRECTOR <u>F. S. Sosa</u> | | ADDRESS <u>Hyattsville, Md</u> | |

U. S. A.

CE 1501

6922

CERTIFICATE OF DEATH

Reg. Dist. No. 214

I. PLACE OF DEATH:

COUNTY MONTGOMERY MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SILVER SPRING, MD. LENGTH OF STAY (in this place) 40 yrs.
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 9218 MANCHESTER ROAD

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD. COUNTY Montgomery
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring, Md. 56
 STREET ADDRESS (If rural, give location) 9218 Manchester Road

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

NORAELUISWRENN

4. DATE OF DEATH:

(Month)

(Day)

(Year)

JULY 161955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

FWWIDOWEDAugust 6, 187480 yrs.1111

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

HousewifeOwn homeNorth CarolinaU.S.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

Wm. Henry EllisFrancesFarrell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

NoNoneMrs. Margaret W. Neumann

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

332X

Immediate cause

(a)

DUE TO

cerebral Thrombosis10 Hours

Antecedent cause(s)

(b)

DUE TO

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

cerebral Atherosclerosis12 years

(c)

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

Rheumatoid arthritis and Heart Failure

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

Yes ☐ No ☐

22. I hereby certify that I attended the deceased from July 9, 1955, to July 16, 1955, that I last saw the deceased alive on July 16, 1955, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

James A. RobertsM.D.8907 Georgia Ave. Silver Spring, Md. July 16, 1955

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

7-18-55Frances PotterWarner E. Humphrey8434 Ga. Ave. Silver Spring, Md.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

JUL 21 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06923

6924

CERTIFICATE OF DEATH

Reg. Dist. No. 26

| | | | | | | | |
|--|--------------------------------|--|---|--|--|--|---|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY Montgomery | | MARYLAND | | STATE Maryland | | COUNTY Montgomery | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
OR TOWN Bethesda | | LENGTH OF STAY (in this place)
2 1/4 yrs | | CITY (If outside corporate limits, write RURAL and give nearest town)
OR TOWN Bethesda | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Pineview Rest Home | | | | STREET ADDRESS (If rural give location)
5509 McKinley Street | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last)
William M. YOUNG | | | | 4. DATE (Month) (Day) (Year) OF DEATH: July 23 19 55 | | | |
| 5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed | 8. DATE OF BIRTH: April 20, 1892 | 9. AGE last birthday 63 yrs. | IF UNDER 1 YEAR
Months 3 Days 3 | IF UNDER 24 HRS.
Hours 3 Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life)
Paymaster Retired | | | 10B. KIND OF BUSINESS OR INDUSTRY:
Wash. Sub. San. Com. | | 11. BIRTHPLACE (State or foreign country): Montgomery Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME:
Robert Lee Young | | | | 14. MOTHER'S MAIDEN NAME:
Lucy Anna Wade | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT & ADDRESS:
Mrs. E. W. Wettengel-Same Item #2 | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) myocardial failure | | | | | | 30 min | |
| ANTECEDENT CAUSE (B) Coronary arteriosclerosis | | | | | | 5 yrs | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Diabetes Mellitus | | | | | | 15 yrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: 0 | | 19B. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) | | 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | |
| | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from June 1, 1952 to July 23 1955 , that I last saw the deceased alive on July 22, 1955 , and that death occurred at 2:20 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE Stephen H. Jones | | M. D. Rockwell M. Jones | | DATE SIGNED 7/23/55 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF 7/26/1955 | | NAME OF CEMETERY OR CREMATORY Monocacy | | LOCATION (City, town, or county) (State) Beallsville Maryland | |
| DATE REC'D BY LOCAL REGISTRAR 7-23-55 | | REGISTRAR'S SIGNATURE Bessie M. Thompson | | 24. FUNERAL DIRECTOR Robert A. Humphrey | | ADDRESS Bethesda, Md. | |

BUREAU V. S.

JUL 26 1955

RECEIVED